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# THE POLYCLINIC

BEING THE JOURNAL OF THE  
MEDICAL GRADUATES' COLLEGE

PUBLISHED MONTHLY, AND EDITED UNDER THE DIRECTION OF  
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BY

JONATHAN HUTCHINSON

**VOL. V.**

JULY TO DECEMBER, 1901

London:

JOHN BALE, SONS AND DANIELSSON, LTD.  
OXFORD HOUSE,  
83-89, GREAT TITCHFIELD STREET, OXFORD STREET, W.

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1901



# THE POLYCLINIC

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VOL. V., No. 1.—JULY, 1901.

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## OUR CLINICAL WORK.

THE departments of work in which the POLYCLINIC is engaged are several and more or less distinct. In one, and that perhaps not the least important, we are a central Society with a large membership engaged in the investigation of disease. It would be an impertinence to compare ourselves with the Clinical Society, most of whose members are highly trained men holding appointments at hospitals. Yet in some respects our organisation may be held to contrast favourably with that of this most successful society. Our meetings are far more frequent, and thus the opportunity for the introduction of patients is more prompt and more easy. This applies not only to examples of recent disease, the phenomena of which may rapidly change, but is also of signal use in facilitating the production of the same patients more than once. Next, in engaging the help of a large constituency of men engaged in family practice we assure ourselves of a very wide field from which to select our material. It is not by any means every case of supreme clinical interest which finds its way to a hospital. We are sanguine that much very valuable material has already, through the agency of our Consultations, been brought into appropriate notice, and very hopeful that as years go on our usefulness in this vocation will steadily increase. The volumes of the Clinical Society's Transactions will be a treasure for all time as containing the well-sifted record of innumerable clinical observa-

tions. There is surely no reason why in the future our own Journal should not in some measure become a rival? The full record of the best of what is brought forward at our consultations is unquestionably the most important object to which the pages of our Journal can be devoted. These records are of permanent value; they concern facts and observations on facts, many of them of very great importance. It would be tedious if we were to attempt to recapitulate even in the briefest manner the clinical topics which have received during the past two years most instructive illustration in our theatres. It is a matter of regret that but a small portion of this material has found adequate record in the pages of our Journal. It has been too much the habit with our members, both those who teach and those who bring patients, to think that the matter is at an end with the demonstration and the diagnosis. Whilst admitting to some extent the plea of pressure of business we yet venture to urge strongly the duty of giving attention to the permanent record for the benefit of others. There is an old Semitic proverb not wholly inapplicable to our present theme. It avers that "the slothful man roasteth not that which he took in hunting." That is, after having endured the toils of the chase he fails at last to give himself the full reward. Just so, some of our members will put themselves to great trouble to bring for demonstration an important case, and a skilled physician will devote much time and care to its investigation, and then neither the one nor the other will take the labour of writing out the record in an accurate but pithy form suitable for publication. They have hunted down their quarry and then refuse to cook it and invite their friends to the feast. If our work is to prosper as it might and as it ought to do, there must be an abatement of this form of indolence.

We would also desire earnestly to lay it as a burden on the consciences of those who have brought patients to the Polyclinic that whenever anything of importance has transpired since the consultation, either the case should be brought forward again, or at any rate, information should be supplied to the person concerned in its record. We want completed cases, not mere fragments of narratives without endings. At the present time there is a most remarkable dearth, almost a famine, of young medical men at leisure. Hence in common with many other institutions the Polyclinic has

found it impossible to fill up as adequately as could have been wished the appointments of clinical clerks. There is not much hope of improvement in this direction and the greater becomes the necessity that all concerned should endeavour as far as possible to complete their own work.

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### TUBERCULOSIS IN MUSEUMS.

WE have learnt with pleasure that in association with the approaching Congress not only is there to be a temporary collection of pathological specimens, but that especial attention will be given to the pictorial illustration of tubercular affections of external parts. Our Polyclinic collection is especially rich in this department. As the distance between the place of meeting of the Congress and Chenies Street is but very short, and we hope that all members of the Congress will pay us a visit, it has been thought best not to diminish our attractions by transferring any part of our collection to the Queen's Hall. This at any rate will apply to such of our original drawings as have already been classified on our walls. We have quite recently (see page 205) catalogued and described those which illustrate what is now known as "Miliary Tuberculosis of the Skin," formerly "Lichen Scrofulosorum," and we shall proceed in our next number with other sections of this most important series. At page 161 an account was given of our illustrations of Lupus-cancer so that it will not be needful to recur to that subject. As remarked at the time the not unfrequent development of epithelial cancer in the scars of lupus vulgaris makes it probable that our predecessors went beyond the truth when they asserted an antagonism between the two diseases tuberculosis and cancer. It probably amounts to not much more than this—that the one is a disease chiefly incident to early life and the other to pre-senile periods, and that in the tendency to one or the other there is a very definite predisponent in inheritance. In connection with inheritance we may note that a recent addition to our collection is a beautiful drawing from a French source showing miliary tuberculosis of the lungs of a young infant.

## SPRENGEL'S SCAPULA.

ONE of the most interesting cases recently in attendance at our consultations was that of a little girl brought by Dr. Travers Smith last Thursday. Although it is now nearly ten years since Sprengel first described the peculiar deformity which is now known by his name, the defect is so rare and in its slighter form so easily overlooked or misunderstood that it has as yet scarcely been noticed by British surgeons. In Dr. Travers Smith's patient there was no difficulty whatever in recognition. The scapula was conspicuously smaller than that of the other side and was placed on a higher level to the extent of not much less than an inch and a half. The clavicle measured at least half an inch shorter than its fellow. We shall describe the case in detail in our next number and give illustrations copied from photographs. In the meantime what should the deformity be called? "Sprengel's malady" is inappropriate, for the condition is one of congenital defect and not of disease and "Sprengel's malformation" would give no clue to its location. If we might name it "Sprengel's scapula" we should have a designation at once short and suggestive.

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## THE FISH-HUNGER OF VEGETARIANS.

LOUIS STEVENSON in "In the South Seas" mentions that "in at least one ocean language, a particular word denotes that a man is 'hungry for fish' having reached a stage when vegetables can no longer satisfy." In these islands flesh food other than fish is rarely obtainable except by cannibalism and hence the great value which attaches to fish. In most of them leprosy has long prevailed, perhaps in all. It is to this fish-hunger, which is common to all people who are for the most part restricted to vegetable food, that those who hold that leprosy is due to fish-eating attribute its prevalence near to fishing stations and its occasional occurrence at a great distance from them.

## SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

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### ABSTRACT OF A LECTURE ON DISEASES OF THE MYOCARDIUM.

BY GEORGE A. GIBSON, M.D., F.R.C.P., EDINBURGH.

AFTER a brief sketch of the historical development of the subject Dr. Gibson proceeded to discuss the relationship existing between the condition of the cardiac muscle and the distribution and efficiency of the coronary arteries. He pointed out that the left artery supplies only the anterior part of the wall of the left ventricle and a limited part of the adjoining portion of the right ventricle, whilst the right artery, of much larger calibre, is responsible for the nutrition of the rest of the muscular mass. It is these anatomical facts that explain the occasional cases in which the carrying efficiency of the left artery has been reduced to a minimum, and yet the heart has been able for a relatively prolonged period to fulfil its functions. Another important consideration in connection with the coronary circulation is the fact that the arteries are "end-arteries"; the anastomoses between the vessels in neighbouring areas of supply are of the slightest. Consequently, when from any cause one of the coronary arteries or one of its branches is blocked or otherwise rendered inefficient, the affected district cannot receive a compensating flow of blood through an anastomosing circulation. There must therefore occur, in the area deprived of blood, a change analogous to the brain softening which follows blocking of a cerebral artery.

Total sudden occlusion of one of the great coronary arteries is a rare event and is almost invariably due to embolism. The result of such an event is sudden death, and *post-mortem* examination reveals

no change in the histological structure of the myocardium, death occurring too rapidly for degeneration or other changes to develop. Total gradual blocking of a coronary artery may result from arterio-sclerosis, and in the affected area it is found that the cardiac muscle is largely replaced by fibrous tissue. The symptoms will be those of gradual cardiac failure with, perhaps, evidences of arterio-sclerosis in the radial, temporal, or other arteries. In addition there may be physical evidences of tricuspid and mitral regurgitation, but the history and facts of the case will not suggest that the valvular defects are the primary events. After arterio-sclerosis has made some degree of advance the final and complete closure of the artery may be brought about by a more or less sudden thrombosis, leading to sudden death, and an area of softening may be found in the myocardium. Gradual partial occlusion of the coronary arteries may be due to a greater or less degree of arterio-sclerosis or to a gradual thrombosis. It is the resulting defective condition of nutrition of the cardiac muscle which explains why pneumonia and various infective diseases take on so serious an aspect when they occur in patients who have passed middle life. Fibrous change—a chronic interstitial myocarditis—develops at the expense of the muscular tissue.

For the clinical recognition of this latter condition it is impossible to lay down any hard and fast rules. The patient begins to suffer from the results of gradual cardiac failure. He gets breathless after slight or moderate exertion, a degree of puffiness is found at times about the ankles, a few crepitations are heard at the bases of the lungs, the urine is apt to be scanty and high-coloured and may contain a slight amount of albumen, and for these symptoms no explanatory physical evidences of organic disease can be detected. It may be difficult or impossible to distinguish between a case in which the heart is the subject of chronic interstitial changes and one where the condition is a fatty degeneration of the cardiac muscle. The latter is certainly hard to diagnose with confidence. The development of an arcus senilis is of no clinical value in this respect, but if, with the above symptoms, there exists a decided tendency to adiposity, a suspicion of fatty change in the heart is justified. Perhaps the safest position is to expect that the symptoms of gradual cardiac failure will be found to depend on a combination of chronic interstitial fibrous changes, with fatty degeneration of the muscular substance.

The prognosis is necessarily a grave one. The gradual diminution of the blood-carrying capacity of the coronary arteries means such a depreciation of the nutritive standard of the cardiac muscle that under stress of any kind the muscle may be strained beyond the possibility of recovery. The treatment must include the establishment for the patient of the most favourable hygienic conditions, the avoidance of mental and physical stress, and the regulation of the excretions. The administration of the iodides—potassium, sodium or hydriodic acid—is of supreme importance. General tonics and haematinics, more especially arsenic and iron, are of value. Should these fail, strychnine will be required, and it may be also cardiac tonics, particularly strophanthus and digitalis.

Dr. Gibson also described cardiac insufficiency existing as a primary fact inherited by certain individuals. It reveals itself with various degrees of severity in children when they begin to enter on a more active phase of life. In such individuals the heart under ordinary conditions meets the demands made upon it, but when these become more intense it breaks down, and there are therefore more or less sudden evidences of cardiac failure. These may include the physical evidences of regurgitation both at the tricuspid and the mitral orifices. The cases are distinguished by the circumstances which lead to the development of the symptoms, and by the fact that under rest both the general symptoms and the cardiac murmurs completely disappear. It may be presumed that under stress the cardiac muscle, weak by inheritance, becomes strained, and the ventricular cavities dilate. The dilatation includes a measure of dilatation of the auriculo-ventricular orifices which are thus not completely closed by the valvular curtains. At the same time the muscular rings which surround these orifices suffer in the general strain of the heart, and by their inefficient contraction increase the opportunity for a regurgitant flow from ventricle to auricle.

It is important to recognise these cases. Failure to do so is apt to lead to a dismal forecast, founded on the existence of cardiac murmurs. The immediate treatment is rest, together with an adequate but not too stimulating dietary, and perhaps general tonics. Every attempt should be made by avoidance of overstrain, by suitable diet and hygiene, by graduated exercises and respiratory drill, to raise the level of the cardiac capacity for endurance.

The lecture was illustrated by a number of microscopical preparations showing various pathological changes in the myocardium. Dr. Gibson intimated that he had excluded from the scope of his lecture myocardial conditions resulting from toxic influences.

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## ABSTRACT OF A LECTURE ON THE ARREST OF PULMONARY TUBERCULOSIS.

BY DR. C. THEODORE WILLIAMS, F.R.C.P.

DR. WILLIAMS, before proceeding to describe the processes by which tubercular disease affecting the lung may be arrested, offered some preliminary remarks in reference to the application of the term "cured" to patients in whom the evidences of phthisis pulmonalis had been more or less completely removed under various methods of treatment. He recognised that in autopsies it is not infrequent to find at the apex of the lung evidences of tubercular disease which had been, for all practical purposes, permanently arrested, and that this experience demonstrated the possibility, under certain conditions, of the "cure" of at least some cases of pulmonary tubercle. Further, it must be allowed that a number of young adults, say between 18 and 30 years of age, who exhibit quite unequivocal symptomatic and physical evidences of phthisis pulmonalis, lose all these evidences under appropriate treatment, more especially from residence at high altitudes. But it is far from certain that in all, or indeed in a majority of these instances, the patient is free from the probability of the disease again becoming active. Experience rather shows that in many of these patients the tubercular process, though arrested, and possibly remaining quiescent for many years, is apt under appropriate circumstances to display further activity, with resulting prejudice to the patient's health. Therefore, even to cases from which all physical signs and symptoms have disappeared, it is safer and more correct to apply the term "arrested" rather than "cured." This consideration still more evidently applies to cases in which physical evidences of a cavity have been replaced by those of

consolidation. This undoubtedly may happen, and the patient may at the same time lose all symptoms of active disease, but in view of the possibilities or even the probabilities of the future, the condition is one rather of "arrest" than "cure." When signs of active disease can be detected in the lung, when the patient still has cough or other symptoms, or when tubercle bacilli are present in the sputa, the application of the term "cured" is quite unjustifiable. Dr. Williams protested against mere improvement in the general condition of the patient, or restoration of his ability to return to work, being regarded as satisfactory proof of "arrest" and still less of "cure." The value of sanatoria is beyond question, but the statistics issued by some of them are highly misleading in consequence of the fact that numbers of patients are claimed as "cured" on utterly inadequate grounds. It will be necessary, before the therapeutic position of the open-air treatment can be definitely fixed, to have standard definitions for the various degrees of improvement effected. The description of any case as "cured" is always more or less questionable, at least it is certain that not many attain freedom from the probability of further developments. But there are cases in which all symptoms cease and physical signs disappear, and there are others in which with removal of the symptoms the previously existing signs of cavity give place to those of consolidation; and to these the word "arrest" is legitimately and properly applied.

Dr. Williams then described, and illustrated by a number of pathological preparations, the methods by which tubercle of the lung may be arrested. These are three in number, viz.: (1) Fibrosis; (2) Local Pulmonary Emphysema; (3) Caseation and Calcareous Infiltration.

(1) *Fibrosis*.—This is occasionally seen in the direct transformation of miliary tubercle into fibrous tissue. The giant-cells throw out branches which undergo fibrillation, and in this way, the nuclei of the cells remaining, is formed a nucleated fibrous tissue. A more frequent illustration of arrest by fibrosis is the formation of a fibrous capsule around a mass of tubercle that has undergone caseation. It may thus come about that the infective material is shut off from the rest of the lung, and the spread of the disease is checked. The fibrous tissue may, however, fail to completely isolate the caseous mass, or possible channels of communication may remain open, or

again, some pathological change may lead to breaking down of the enclosing capsule, and any one of these events will be the occasion for further extension of the disease. But it is quite possible that masses of caseous matter may be securely encapsulated, and that in process of time the lung may be mainly converted into fibrous tissue containing a few caseous nodules. A third example of fibrous change is seen in the closure, more or less complete, of tubercular cavities. Absolute cicatrization is rare, but the size of the cavity may be much diminished by fibrous thickening of its walls, and if, with this, the communicating bronchus is closed, all the cavernous signs will disappear and the sputa will cease. This process is in the majority of instances a very slow one, but it occasionally occurs with unusual rapidity. Even in the course of two or three months it may be found that the cavernous physical signs have completely disappeared. The effects of shrinking of the new tissue when fibrosis occurs at all extensively are seen in the displacement of the heart, mediastinum, stomach or liver, and in flattening, more or less extreme, of the wall of the chest; there may even be considerable curvature of the spine and depression of one or other shoulder. It has also to be noted that an extensive fibrosis may cause the patient much inconvenience in the shape of breathlessness, even though it has prolonged his life by putting a stop to extension of the tubercle.

(2) *Local pulmonary emphysema.*—The emphysematous condition is explained by the fact that the pulmonary vesicles in the neighbourhood of a tubercular mass are, in the act of coughing—that is, the glottis being closed during a forcible expiratory effort—subject to unusual pressure from the intra-pulmonary air, and at the same time, owing to the condensed or cicatrised condition of the neighbouring tissue, they have a lessened external support. Under these circumstances, therefore, they become unduly distended or emphysematous, and in this way a barrier may be formed to the spread of the tubercular disease. It is the development of emphysema which explains how an apex, giving at one time dull percussion from tubercular condensation may, at a subsequent date, become resonant to percussion, and in the same way is explained the supraclavicular bulging produced in the act of coughing. The effect of the breathing of air at high altitudes is somewhat similar. Neighbouring healthy

air vesicles become distended, and the dulness of the affected district is lost in consequence of the resonance due to this distension. In some instances the emphysematous change extends widely through the lung, and the patient is "wheezy" in consequence of a diminished extent of pulmonary respiratory area. Such patients are sometimes subject to paroxysmal attacks of breathlessness and hence become recognised as "asthmatic." The explanation is, that in these cases the bronchial glands become enlarged and pigmented. As a consequence of the glandular enlargement the pulmonary plexuses may be irritated, and thus spasmodic attacks of dyspnoea are induced. The non-recognition of the true nature of the case is all the more likely to occur as an extensive development of emphysema may completely conceal the physical signs of tubercular disease. It may, indeed, happen that only at the autopsy will it be discovered that an emphysematous lung conceals a tubercular lesion, such for example, as a central cavity with dry walls puckered by fibrotic changes and communicating with a bronchus the closure of which explains the absence of cavernous signs. It is these facts which emphasise the need for caution in the diagnosis and prognosis of "asthmatic" patients who give a history of haemoptysis or other suspicious occurrence.

(3) *Caseation and calcareous infiltration.*—The change in caseation is a necrosis with fatty degeneration of the elements of the tubercular growth, and the condition may extend to the tissue in the neighbourhood of the tubercles. Should the caseous matter soften and liquefy a cavity is formed. On the other hand it may remain without much change and become enclosed in a fibrous capsule as already explained. The third possibility is that lime salts may be deposited in the caseous matter, and this calcareous infiltration is one of the most certain proofs of old and obsolescent tubercle. Usually this change occurs in the centre of the caseous mass and takes place slowly. The change may, however, affect any part of a caseous area, and it sometimes develops rapidly and may lead to prolonged arrest of pulmonary tubercle. An interesting occurrence in connection with calcareous infiltration is the fact that phthisical patients occasionally spit up particles of lime salts. This is sometimes followed by profuse haemoptysis, which would appear to suggest that the calcareous change may possibly affect the arterial walls.

In addition to various pathological specimens the lecture was illustrated by the relation of a number of personal experiences emphasizing the clinical application of the several pathological facts.

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## ON CONGENITAL ABERRATIONS OF GROWTH TENDING TO IRREGULAR LOCAL HYPERSTROPHIES.

BY JONATHAN HUTCHINSON.

GENTLEMEN,—Some years ago a man died in the London Hospital who had long been cared for there in a private ward on account of his extraordinary misformations. He was rescued from the necessity of exhibiting himself publicly for a livelihood by the kindness of the hospital authorities. He was known as the “Elephant Man.” His skeleton and models of his state during life are preserved in the London Hospital Museum, and his case was published by my colleague, Mr. Treves (now Sir Frederic Treves, whom we all congratulate). Briefly, it may be said that in him enormous local hypertrophies of skin and bones had occurred. It was not one tissue alone, but several that were affected. You will find some good drawings and photographs of him in our collection.

The poor woman whom we had before us a few weeks ago and whose condition is imperfectly illustrated in the portrait which I now present, affords an example, on a smaller scale, of similar defects. She was brought under our observation at the Polyclinic by Mr. Sydney H. Carr, of Blackheath. She has numerous cutaneous and subcutaneous fibromata, like those of molluscum fibrosum. She has also an osseous enlargement on the left side of her sternum, which possibly involves some of the ribs. Her principal defect, however, is the onesidedness of her face. Apparently, most of the bones in the right half of her head are thickened and enlarged. Nothing in the nature of a pedunculated exostosis can be detected anywhere, but her forehead and cheek are bulged by bony hypertrophy, and her eyeball pushed forwards, probably by growth behind it. As in the case of the “Elephant Man,” although



both sides of the body and limbs are affected by some of the lesions, yet the tendency to non-symmetrical development is very marked.

Our interest in these extraordinary and fortunately very rare cases seems to me to be chiefly in the illustration of pathological law which they afford. They help us to connect together and bring into line a number of deformations to which have been given different names. Exostoses, moles, dermatolysis, molluscum fibrosum, and unilateral hypertrophies are all collected together in the same body. The inference is that all these forms of irregular excess in development are closely allied as to their primary cause. It would appear to be possible for that wonderful power of vital co-ordination by which the several tissues and structures of our bodies are all kept in due relation with each other, to fail in certain regions. Fortunately the failure is often strictly limited, and then we have only an ordinary mole or "mother's mark." This mole may be vascular, it may be pigmented, it may grow hairs, or it may exhibit lumpy excrescences like a turkey wattle. To go a little further, we may have great pendulous folds of skin like those of a pachyderm. Sometimes only small deviations from the normal are to be observed at birth, but they increase as growth advances, and now and then throughout the whole of life. Thus, as in molluscum fibrosum, certain structures appear to be emancipated from control, and go on growing to the end of their possessors' days, without any regard to either use or ornament. Exostoses and some other hypertrophies usually cease to grow when adult age is attained. In the case of moles, to which I again allude because they supply us with one of the simplest types, we often find multiplicity and considerable variety in character in different positions. This would seem to imply that the defect in nutritional control is not merely local, but pervades the whole system, or, at any rate, involves the whole external integument. Yet, side by side with abnormalities, we may usually see structures which are perfectly natural. The law which I want to hint at is a general weakness of rule which has its manifestation by local outbreaks, and it is, I repeat, as seeming to illustrate this, that I feel especial interest in the case which has been before us, and the yet more exaggerated one to which I have made reference.

We may note with great interest that in most of these cases there are present very definite deviations from bilateral symmetry. There may be lesions on both sides of the trunk and in all the limbs, but scarcely ever are they alike on both. This was very definite in the "Elephant Man" and also in our patient. It is still more instructively shown in a skull which I have frequently exhibited to you, and in which hyperostoses and exostoses are absolutely limited to the bones of one side only of the head and face. It is also illustrated in the curious conditions known to specialists as *Ichthyosis unius lateris*.

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## ON A CASE OF ALBUMINURIA, CARDIAC HYPERTROPHY, AND RETINITIS.

BY C. O. HAWTHORNE, M.D., M.R.C.P.

*Tuesday, May 7, 1901.*

GENTLEMEN.—This patient, a man of 50 years, is reported to have been suffering during the past year or so from anaemia. He has on several occasions improved for a time, but pallor and breathlessness have returned again and again, and at times a small quantity of albumen has been detected in his urine. I need hardly say that anaemia is never a satisfactory diagnosis, more especially in a male patient who has reached middle age. In young women we often have to be content with recognising anaemia or chlorosis because our ignorance of the cause of this condition does not permit us to advance further in the investigation. And experience provides us this additional excuse and satisfaction, namely, that in these instances we know that as a rule we can cure the patient's disease though we are unable to explain it. But even here it is hardly wise to be content with the mere recognition of anaemia and the administration of iron. Every case of anaemia in a young woman is not an example of chlorosis. Apart from the possible presence of some organic disease, the anaemia may depend on such factors as insufficient or unsuitable food, carious teeth, imperfect digestion, constipation, defective hygienic surroundings, &c., &c. If any of

there exists iron will at best attain a partial success. Consequently, even in young women the recognition of anaemia claims at least an effort to determine its causation. But in adults, and more especially in male adults, anaemia ought never to be a resting place either for diagnosis or treatment. It is a symptom arising in many and varied circumstances, some of which are of a most serious nature. Therefore, as it is at once evident that our present patient is anaemic, we will proceed to make a physical examination to try and discover on what, in this particular case, the anaemia depends. If we fail to detect any organic lesion we may have to proceed to make a microscopical examination of the blood, and if this and all other methods fail to lead us to a diagnosis we shall still be bound to suspect the existence of some serious mischief which has not yet come within the reach of physical examination.

Now, when I uncover the patient's chest, it is manifest that he has a considerable degree of cardiac hypertrophy. The impulse extends to the sixth space, and is an inch or more outside the nipple line. In the epigastric notch there is a visible and tangible pulsation as if from enlargement of the right ventricle. Over the apex region I hear a very distinct systolic murmur which is also heard, and with about the same degree of intensity, along the line extending from the cardiac apex to the foot of the sternum. It does not extend towards the left axillary line as though it took origin at the mitral orifice, and the fact that the second sound is much louder over the aortic than over the pulmonic area is also opposed to the theory of mitral disease. From its area of distribution it suggests rather a tricuspid source, and it possesses the "superficial" whiffing character which tricuspid regurgitant murmurs usually possess. At the same time it is to be noted that there is no visible pulse in the veins of the neck which is frequently so conspicuous a feature in tricuspid regurgitation. Of course tricuspid regurgitation could not account for enlargement of the left ventricle, whilst a condition of mitral regurgitation would be a possible explanation of the existing extension of both sides of the heart. There may, however, be some other factor in the case which will help us to get rid of any uncertainty as to the physical cause of the systolic murmur. It is hardly necessary to say that we cannot regard the murmur as functional or haemis. Its presence over the ventricular area and not over the base,

and the fact of cardiac hypertrophy, are sufficient to negative such a suggestion. And neither on the hypothesis of mitral, nor on the supposition of tricuspid disease, does its existence throw any light on the anaemia. There is one form of cardiac valvular disease which is often associated with a marked anaemic appearance of the patient, namely, aortic regurgitation. But mitral or tricuspid regurgitation, if they affect the colour of the patient at all, do so in the direction of cyanosis rather than anaemia. Possibly if an abnormal condition of either of these valves is the result of a recent attack of rheumatic fever the anaemia produced by that disease may still be present. But it is a consequence of the rheumatism, not of the valvular flaw. In the present instance we cannot explain the anaemia in this way because the patient, according to his own statement, has not had rheumatic fever either recently or indeed at any time. Therefore, whilst we have no doubt that there are organic changes in the heart, we are still without an explanation of our patient's anaemia.

Let us now examine the urine. We can only obtain a small sample, but it is quite sufficient to show us the presence of albumen in moderate amount. But so far this only raises another problem. For the albuminuria may mean either primary kidney disease (which would account for the anaemia) or it may be an expression of passive congestion of the kidney due to the cardiac-valve defect. There are some facts in the case which seem at first sight to support the latter explanation. There is, as you see, a moderate degree of oedema in the legs and feet, and on examining the lungs you find impairment of percussion over the bases and some muco-crepitant râles. There is, therefore, some measure of passive engorgement in both the pulmonary and systemic circulations, and the latter may well include passive congestion of the kidney with resulting albuminuria. Is the present case, then, one in which cardiac disease was the primary fact and the renal condition a secondary development, or is it one in which a primary disease of the kidneys has led to cardiac hypertrophy and dilatation? A combination of the physical evidences of heart disease and albuminuria frequently leads to a discussion of these alternative possibilities, and sometimes the questions are not easy to answer. In the present instance we can decide without much doubt that the renal condition was almost certainly the primary fact. And this for several reasons. First, in the urine itself we have certain facts which suggest

that the quantity is not diminished, as is to be expected in passive congestion of the kidneys. The colour, as you see, is very light, almost watery in fact, and the specific gravity is low. The patient believes that he passes urine in excess, and he certainly passes it too frequently, so that for many months he has been compelled to rise two or three times every night to empty his bladder—a symptom which occurring in middle age, or even before this, is strongly suggestive, in the absence of disease of the bladder, of chronic kidney disease. In later life, of course, undue frequency may mean enlargement of the prostate. Again, we find that our patient has rigid and tortuous arteries, a condition commonly associated with chronic interstitial nephritis. On the other hand, the state of the heart is not one which suggests a primary endocarditis. The systolic murmur appears to depend upon regurgitation at the tricuspid orifice, and this, as we know from experience, is very rarely the result of endocarditis. It means, rather, that the right ventricle and its auriculo-ventricular orifice are dilated, so that the curtains of the valve fail to close the latter during systole. This dilatation is always secondary to circumstances which strain or exhaust the energy of the right ventricle, as mitral disease, pulmonary emphysema, or long-continued malnutrition. Further, our patient has considerable hypertrophy of the left ventricle, which tricuspid regurgitation will not explain. But hypertrophy of the left ventricle is a frequent associate or consequence of chronic interstitial nephritis, and the same condition will account for the exaggerated aortic sound. In time, hypertrophy is succeeded by dilatation, and if we conceive that in the present case dilatation has occurred and has extended to the right ventricle, we have an explanation of the systolic murmur, of the congestion of the bases of the lungs, and of the oedema of the lower limbs. These seem to me adequate reasons for diagnosing the case as one of chronic interstitial nephritis with commencing cardiac failure. If any doubt as to the accuracy of this diagnosis should still remain, it is at once dispelled by the use of the ophthalmoscope. I find that there is in each eye an appreciable degree of optic neuritis, and that in lines radiating from the macula are white spots and patches, often described, though not quite accurately, as distinctive of albuminuric retinitis. This condition is certainly never produced by passive congestion of the kidney. Apart from other facts, it concludes our diagnosis that in

the present patient we are dealing with a case of kidney disease. The age of the patient, the insidious onset, the absence of oedema until cardiac failure has developed, the considerable hypertrophy of the left ventricle, the arterial degeneration, and the abundant urine with albumen in relatively small amount, render it practically certain that the form of kidney disease is chronic interstitial nephritis.

Regarding prognosis, our patient presents rather serious facts. In any case, the chance of curing chronic interstitial nephritis is a very slight one, though with care the patient may often live for many years. But here we have signs of serious import. In the first place, there is retinitis. This may be associated with albuminuria during the course of pregnancy without necessarily increasing the gravity of the prognosis. It may even occasionally be found in renal disease apart from pregnancy, and yet the patient may recover. But this result is rare and is always, I believe, found in cases where the renal disease is acute or subacute, and is of the parenchymatous form, with oedema as an early and prominent symptom. But in chronic interstitial nephritis the development of retinitis is a sign of grave omen. In addition, we have here decided evidences of cardiac failure: oedema of the lower limbs and of the bases of the lungs, and a pulse which, though of moderately high tension, is not quite regular. Further, the state of the respiration is, I think, a claim for even more urgent alarm. Everyone must have observed the respiratory distress exhibited by the patient—a degree of distress quite out of proportion to the physical facts detected on examination of the chest. That, however interpreted, is a very anxious or even an alarming fact, and it may well be the commencement of severe uræmic manifestations. These circumstances, in my judgment, give evidence of danger to life in the immediate future.

The first measure of treatment certainly is to keep the patient in bed and to restrict his diet to milk. The bowels should be freely opened, say by compound jalap powder. By saline diuretics, as acetate or citrate of potassium, the kidneys may be rendered more active, and some sweet spirit of nitre will help to secure diaphoresis. A saturated solution of cream of tartar taken *ad lib.* is valuable, both as a diuretic and as a saline purgative. Pilocarpine, I think, would be risky with evidences of oedema of the lungs, but a steam bath, whilst the patient is lying in bed, might be ordered. Unless

the action of the heart improved promptly under rest I should add digitalis to these remedies, combining it with nitro-glycerine in order to neutralise its contracting effect on the smaller arteries. Guy's pill, containing digitalis, squill, and blue pill, is often an effective diuretic, and though it is usually said that mercury is contraindicated in albuminuria, I should certainly try it for a time, in the event of the other treatment failing. At the best, you can hardly expect to do more than prolong the patient's life for a few months, and there is at least a chance of a much earlier and fatal termination.

## NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

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### MEDICAL CASES.

BY DR. BOWLES.

*Tuesday, May 21, 1901.*

#### I.—*Cases of Rickets.*

WE have before us for consideration two cases of impaired nutrition in children; the one, scarcely two years old, is sent us as a typical case of Rickets with all its signs well marked; large square-looking head with marked frontal prominences; heavy features; soft flabby tissues, muddy and ill-coloured skin, thin hair without "gloss," head sweatings, enlarged epiphyses, small nodules on the cartilages of the ribs, the so-called, rickety rosary, prominent belly, recurrent diarrhoea, and frequent attacks of bronchitis, &c. Evidently the child is improving somewhat, under the judicious treatment of Dr. Rankin, for the child is less fretful and the limbs are less wasted, and—the mother says—much more vigorously used of late.

Fortunately there are, as yet, only slight evidences of the deformities of body, chest, or limbs so common in the more neglected cases of this disease.

Its most common causes are hygienic and dietetic, especially the "bringing up by hand," so common nowadays among both rich and poor; and the absence of animal fat and proteids in the food.

## II.—*Case of Tubercular Disease of Bowel.*

In this second case, a child of six years old, are also abundant evidences of impaired nutrition ; but of a different kind. The head and features are small and well defined ; the skin is clear and transparent ; the limbs, hands, and feet small and neat ; and there are no swellings or deformities to be found anywhere.

The history is that she was admitted to hospital in April last, on account of cough, sweatings at night, diarrhoea, and emaciation. There was found some deficiency of expansion of the left side of the chest, which is now nearly restored. The respiratory murmur throughout the left upper lobe is rough, with prolongation of expiration ; and there is now, as you hear, well marked percussion dulness, but no râles.

The heart is normal.

There is some fulness of the abdomen, but no tenderness, and no sign of anything abnormal with the enclosed organs.

The sweatings have ceased, but the motions are still loose, mucoid, sometimes blood-stained, and offensive.

The examination of the blood shows :—Red corpuscles, 2,900,000 ; the white corpuscles, 8,400 ; *i.e.*, in about the right proportions, but much less in amount.

The up and down temperature chart so marked on admission, has, for the last fortnight, become practically normal. The child, we are told, is manifestly improving under bismuth and B. naphthol. internally, with large nitrate of silver enemata.

We are asked for diagnosis, but first I will ask you to look carefully at these two pathological specimens. They are excellent examples of tuberculous ulceration of the colon. During life the child suffered from symptoms similar to the patient now before us, and I think we shall agree that our patient is suffering from a similar morbid condition of the bowel at the present time. Clearly the history and appearances are confirmatory evidences.

## III.—*Case of Paralysis in a Child.*

Our third case, aged 9 years, is well grown, but delicate looking. Between four and five years ago, during the process of recovery from scarlet fever, she suddenly lost the use of her right leg, followed by

muscular wasting below the knee. There was no loss of sensation, but occasional incontinence of urine. The knee-jerks were exaggerated, especially the right.

Babinski's sign was marked on the right side; no clonus; some tendency to talipes varus.

The history also relates a primary loss of power in both legs, with rapid recovery of the left. The grasp of the right hand is not quite so good as that of the left, nor is the right arm quite so well developed.

There is reaction of degeneration in the anterior tibial and peroneal muscles of right leg.

We are asked: "Is the lesion spinal or cerebral?" Is it, that is, a case of infantile paralysis or infantile hemiplegia?

To help us in our deliberation I hoped to have had a typical case of infantile paralysis here, for comparison; but unfortunately the patient has not arrived, so we must picture it to ourselves, as shortly defined in our text-books, "anterior poliomyelitis," a paralysis supervening suddenly in young children, with fever; and terminating with paralysis and atrophy of certain groups of muscles. It has long been observed to be secondary to specific fevers, and to many febrile conditions coincident with dentition and catarrhs of all forms.

At the meeting of the British Medical Association at Edinburgh, in 1898, Dr. Buzzard, in opening a discussion on the "Influence of micro-organisms and their toxins in the production of diseases of the central and peripheral nervous system," dwelt strongly on the evidence afforded by epidemics of infantile paralysis that the disease was of infective origin. He pointed out that in the epidemics recorded by Medin, Caverly, and W. Pasteur, although exclusive adherence to the classical type of infantile paralysis was not observed, there yet remained so overwhelming a preponderance of cases pointing to this affection as to render it practically certain that the essential cause of the disease was that which lies at the origin of acute anterior poliomyelitis, although in many instances other portions of the nervous system were affected coincidentally or independently. He thinks that the infective agent, whilst its dominant influence is excited upon the ganglionic cells in the anterior horns, may affect many other portions of the cerebro-spinal

axis; and, as an illustration, remarks that convulsions, acute pains, or spasticity may be occasionally observed in infantile paralysis. These suggestions of his may well apply to the case now before us, and perhaps supply the key to the diagnosis which we are asked for. Clearly ours is a mixed case as regards symptoms; the reaction of degeneration in a group of muscles denoting lesions in the spinal cord, whereas the activity of the knee reflexes and other symptoms indicate a cerebral origin.

Babinski's sign—extension instead of flexion of the big toe on tickling the foot sole—is not to be elicited to-day, but as the sign is at present new to the profession, its real value as a symptom is not yet quite determined. It is present in infants for some months after birth, presumably from the, as yet, undeveloped state of the lateral columns of the spinal cord, and lately I found it unmistakably present in the profound coma of apoplexy.

#### IV.—*Case of Suspected Phthisis.*

Complains of cough and pain in chest since February, 1901; loss of flesh; sweats at night. *Family history*, good. *Past history*, good. Rather intemperate formerly. Attributes his present illness to exposure in the course of his business. Expectoration very profuse. *Physical examination*. Percussion note good over whole of chest. Cardiac dulness low down. No murmurs. A little doubtful crepitation at right apex posteriorly, but not more than the presence of emphysema would account for.

Here we have a history suggesting phthisis accompanied by alcoholism. The patient is very thin and has a highly congested state of the small vessels of the face; the physical signs of emphysema are present, whilst those of phthisis are few and ill marked.

For the present we must defer our diagnosis, examine the expectoration for the tubercle bacillus, and treat the case on rational hygienic principles.

#### V.—*Case of Lymphadenoma.*

K. B., 23, single, maidservant, complains of swelling of lymphatic glands on both sides of neck, left axilla, right supraclavicular fossa, and right groin. Breathlessness on exertion and great weak-

ness. *Family history*: mother died of heart disease; father alive and healthy; two brothers living and quite well. *Past history*: suffered from swollen legs at the age of 20; treated for anaemia by medical man, and sent into the country; made a good recovery.

The swollen glands do not present the character of ordinary tuberculous glands, but rather that of lymphadenoma, and since we have breathlessness and great weakness combined with them, we may assume the case to be probably one of lymphadenoma, and suggest watching, a change to Margate, and arsenic or cacodylate of sodium as a suitable treatment.

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## CASES WITH COMMENTS FROM THE SURGICAL CLINIC.

BY MR. HUTCHINSON.

*Thursday, April 4.*

**CASE I.—*Herpetiform Morphaea distributed by the intercosto-humeral nerve. Arrested development of mammary gland.***

(Dr. Carr's case.)

Amongst the patients who presented themselves on April 4 there were some cases of unusual interest. In one of these a girl of 16 had an ivory patch of morphaea extending down the inner side of her right arm from the edge of the axilla nearly to the internal condyle. In association with it there was another patch on the upper pectoral region on the same side. We were told that these patches had been noticed simultaneously, about four years ago, as groups of white spots which subsequently coalesced. The patches are apparently undergoing spontaneous resolution, and we were shown on the inner side of the thigh of the same side a long shallow trough in the subcutaneous cellular tissue which occupies the site of a former patch. The mammary gland on the affected side is not more than half the size of its fellow. I pointed out that the patches on the chest and inner side of arm were obviously located by the intercosto-humeral nerve and that on the thigh on one of

the branches of anterior crural. The term herpetiform was, I remarked, the one most applicable to this kind of arrangement. The arrangement was exactly that of herpes zoster and was in like manner brought about through nerve influence on nutrition. In zoster the local effect is the production of vesicles which usually last only ten days, whereas in morphœa it is that of lardaceous spots which may last as many years. In both the tendency is finally to local recovery. Sometimes this recovery is perfect, but often in morphœa we have to observe, as in this instance, that a certain amount of atrophy of tissues is left behind. Neither in zoster nor in morphœa are the nerve-produced changes restricted to the skin itself. The subcutaneous cellular tissue, the muscles, and in morphœa even the bones, may be affected. In the latter the changes being very slow and of long persistence, much depends as regards final result upon the age at which the patient was attacked. If the patient were young and the tissues in process of growth their growth would be arrested and a permanent want of symmetry would result. Of this we have frequent examples in what is called "hemiatrophy of the face." In our present patient it was shown by the arrested growth of the mammary gland.

CASE II.—*Housemaid's knee—Multiple Fibrous Tumours in Pressure Positions.*

(Dr. MacEvoy's case.)

A woman, Mrs. Ambrose, aged 36, presented a peculiar condition of housemaid's knee. On the front of each knee, one above the other, were two tumours, rounded and very hard. The largest was as big as a small Tangerine orange, and the smallest as large as a chestnut. These tumours were said to have been slowly developing for six or seven years. My diagnosis of them was that they were bursæ which had undergone solidification, and in explanation of there being two on each side I suggested that the woman had probably used expedients to prevent undue pressure on those which first appeared and thus thrown the pressure on to another part. That her tissues were exceptionally prone to resent the influence of pressure appeared to be shown by the presence of hard nodules

under each olecranon. These were not exactly on the tip of the elbow nor did they appear to be bursæ but rather quite solid. There was another lump, solid and rounded, in the palm of one hand. It was suggested that these might possibly be of the nature of neuromata, but they were not painful. They were certainly fibrous. I advised that the tumours in front of the knee should be excised.

CASE III.—*Washerwoman's Paralysis*.—*An exceptional form of Skin Disease—Morphea? Lichen planus?*

A washerwoman, aged 39, presented us with an example of that failure of the use of the hands which sometimes occurs in those of her occupation. She complained that the hands for the last few months had been weak and that they felt numb. We could not localise any degree of anaesthesia nor prove that any single muscle or group of muscles was defective. On this account I took some exception to the term “peripheral neuritis” alleging that there was no proof that any nerve-trunk was affected, and that the physical cause of the nerve exhaustion must remain obscure.

This patient presented another affection which was perhaps of yet more interest. Her shoulders were covered over with little spots of white resembling on a small scale the lardaceous deposits of morphea. These spots were slightly glistening. They were perfectly smooth, but many of them showed in the centre an indistinct depression. There were some long streaks of a similar kind on the sides of the abdomen. It was reputed that these patches had been present about two months, but very possibly they had existed much longer. They were not irritable. In discussing the diagnosis we took chiefly into consideration herpetiform morphea and lichen planus. I produced for comparison the portrait of a patient whom Dr. Vinrace, of Birmingham, sent to me some years ago. In that instance patches exactly similar to those which our present patient displayed were developed on the fronts of the wrists and some other parts. They persisted with exceedingly little change for some years, and I have recently heard from Dr. Vinrace that the woman has died of quite independent disease, but with the affection of her skin but little altered. It had never given her any material trouble. The subject of that case was shown at one of the meetings of the

International Dermatological Congress, and I believe that the general impression inclined to favour the diagnosis of an exceptional form of lichen planus. Looking, however, at the fact that the eruption persisted, and did not materially increase or show tendency to change, and comparing it with the case now under our notice, I was inclined rather to the belief that both were examples of an exceptional form of morphœa. It seemed probable that the morbid changes were located around hair follicles. To this conclusion the little depression in the centre of many of them seemed to point. No opportunity in either case had been afforded for anatomical examination. The condition was one of those to which in former times the term "vitiligo" had been applied but without any very definite conception of its meaning.

[A case which should be compared with this is that figured by Hans Hebra as No. XIV. in the International Atlas under the name of: "Hyper-keratosis striata et follicularis." The portrait shows the eruption in the bends of the elbows.]

CASE IV.—*Multiple Lipomata of very large size placed symmetrically.*

(Dr. Dixon's case.)

A Jewess, aged 57, naturally stout, presented enormous fatty growths on her shoulders. These growths were as large as an infant's head, circumscribed, and somewhat lobulated. There were similar ones on both hips, covering the iliac crests. We were told that those on the shoulders had commenced to grow four years ago, and those on the hips a little later. I remarked that these tumours, although symmetrically placed, were quite different in character from the diffuse lipomata which we are accustomed to see in beer-drinking men. They were not diffuse, but circumscribed masses of fat which, if it were thought worth while, might easily be removed. Nor were they developed in the positions in which we so frequently see the diffuse hypertrophy. Partly on account of their large size and multiplicity, but chiefly because they were not causing any material inconvenience, I advised that they should not be interfered with, but that the patient should be content to adopt a regimen

non-conducive to fatty growth, and take three times a day twenty drops of liquor potassæ with ten of tincture of nux vomica, to obviate any depressing influence from it. It should be added that there was also a large mass of fat between the shoulders.

CASE V.—*Case of Leprosy in the Maculo-erythematous Stage, almost wholly without Anæsthesia.*

(Dr. Coulter's case.)

The patient in this instance was a man aged 37, who, although born in England, had lived most of his life in Calcutta. He had noticed in the beginning of his eruption some small brown spots on his back and on his feet. A few months later he had noticed that his left foot began to droop. Since then fresh patches had been appearing at intervals of a few months, but his general health had not failed. He was now covered over limbs and trunk with "café au lait" or "scorched" patches, some of them very large and all showing ill-defined borders. There was not a trace of anything like a tubercle visible, nor were there any anaesthetic areas. On some parts, however, sensation was probably a little defective. His feet and hands were just a little numb, especially in the ulnar nerve regions of the latter. They were by no means, however, without sensation, and he could still use his fingers for any purpose. He said that his fingers felt a little numb at the tips. The hands and feet were dusky, but not definitely swollen. The extensor muscles in front of his left leg were definitely atrophied, a long hollow extending up the upper side of his tibia. I placed by the side of his legs a drawing which showed a precisely similar condition, taken from the Museum Collection. I drew attention to the fact that it was very difficult to tell whether the arms were erythematous or not, there being no definite patches. My impression was that the whole of the skin of his hands and feet was really in a condition of leprosic erythema, and I reminded those present that the conditions presented were exactly similar to those in a boy who was attending our Clinic. In both cases, on the covered part of the trunk, the patches were definite, and between them were areas of pale skin; but in both, on the extremities, this contrast was lost, and the whole surface was

dusky and brown. In the boy, on the face, tubercles were now in process of development. In both patients the trunk of the ulnar nerve on both sides could easily be felt to be thickened and hard, although in neither was there complete anaesthesia in the area of its distribution nor marked atrophy of its muscles. We might believe, however, with probable truth, that the muscles were weak, and that the skin was somewhat numb; the condition of neuritis not having advanced to complete disorganisation. On the tips of the elbows, in the man now under our observation, the patches had become scaly, and were much like those of psoriasis.

In speculating as to the cause of leprosy, I asked attention to the fact that both these patients had lived in leprosy districts, but that neither of them knew of any special exposure to contagion. Neither of them had had any primary sore suggestive of local contagion, nor indeed is such lesion ever witnessed in leprosy cases. The earliest recognised stage is that of erythematous patches which are distributed quite symmetrically. This distribution suggests that they come from some internal cause and do not originate on the surface. That having once appeared they spread by self-infection seems extremely probable. These facts are much more suggestive of a dietetic cause than of any other, and an instructive parallel might be traced between certain forms of lupus erythematosus and leprosy. In the case of the man we were told that Bombay ducks (dried fish) had been a favourite article of diet.

#### CASE VI.—*Generalised Ringworm.*

(Dr. T. Smith's case.)

In this instance a boy of 4 had ringworm patches all over his trunk and limbs. Some of them were very well characterised as rings. Some were as large as crown pieces, others as shillings. A few were very small and ill-characterised. I placed by the side of the child a portrait of a girl showing a similar condition of things, and remarked that in neither of the cases did the eruption flourish on the scalp. It would appear that in the cases of ringworm on the limbs and body the fungus has a preference for epidermic structures rather than for hairs. It is rare in severe ringworm of the scalp to see it on the trunk also, and it is exceptional in such conditions as our patient offered to see much of it on the scalp. The

peculiarity probably is rather in the patient than the fungus, for cases occur in which one patient in a family of children shows it severely on the scalp and another on the trunk. In adult life, if ringworm spreads anywhere it will be on the naked skin of the trunk and limbs and not on the scalp.

*On Thursday, May 9, the following cases were those of most interest :—*

**CASE VII.—*A Pruriginous Syphilitic Eruption. Possible Chancre of Tonsil.***

A woman, aged 54, showed us a mixed and very pruriginous eruption which consisted of lichenoid papules and pustules. These occurred on the trunk and limbs generally, but were abundant in the bends of the elbows and palms of hands. The eruption was said to have been out two weeks, and to have followed chills which were said to have occurred six times a day during the preceding fortnight. Many of the lichenoid papules were very like those of a syphilide, but against this diagnosis was the fact that there had been much itching and that many were pustular. On examining the throat, we found a deep ulcer with gray edges in the left tonsil, whilst there was none in the right. There were also enlarged and painful glands in the left side of the neck. We were told that the woman was the aunt of a little boy, aged 6, whose case will be found mentioned at page 87. In this boy a syphilitic eruption had followed a sore on the middle of his chest—apparently an ulcerated nævus. There was no history as to how his aunt had been infected and it seemed somewhat probable that the primary sore was in her tonsil. In explanation of the alleged pruriginous character of the eruption, I suggested that there might be scabies mixed with it, but of this we did not obtain positive proof. The febrile phenomena which were described were, I remarked, not very uncommon during the advent of secondary symptoms.

**CASE VIII.—*Solid Edema of the whole of one Lower Extremity. (Smooth Elephantiasis.)***

(Dr. Carrigan's case.)

The subject of this case was a man aged 63 in whom the enlargement of the leg was stated to have been in progress for more

than two years. The skin was smooth and tense. The enlargement began at his ankle and extended up to near the crest of the ilium, the limb being nearly twice the size of its fellow. It was very firm but pitted on persistent pressure. I remarked that we had a good example of what I had once described as "one-leg-oedema" and that in searching for a cause we had to think first of lymphatic obstruction originating probably in some slight injury and an attack of erysipelatous inflammation. In some instances, however, of which this was one, there was no history of traumatism, but the condition developed gradually. In nearly all, however, recurring attacks of inflammation would occur which were not to be distinguished from those of erysipelas. Our patient admitted that he had once been sent into a hospital with redness and swelling of the leg and that the diagnosis placed on his board was "erysipelas." He alleged, however, that his leg had been swollen long before this occurred. With the exception of the attack referred to the state of his leg had never disabled him. As regards the use of the word "Elephantiasis," it was to be admitted that this was one of the conditions which was introductory to the states which receive that formidable name in tropical countries, and of which we see a few examples in England. It was the smooth non-tuberculated form. The word elephantiasis is, however, a name for a final result rather than for a disease, and it is better to take cognisance of a variety of causes which might conduce to it than to employ, prematurely, a name which implies nothing as regards the knowledge of cause. Although the man would not admit any injury in the first instance I still persisted in my belief that it had probably begun from some slight trauma.

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#### REVIEWS AND NOTICES OF BOOKS.

I.—**TRAVELS IN THE INTERIOR OF AFRICA FROM THE CAPE OF GOOD HOPE TO MOROCCO FROM THE YEAR 1781 to 1797.**  
Translated from the German of Christian Frederich Damberger. London: Longman and O. Rees, 1801, pp 297 with map and plates.

II.—LETTERS WRITTEN FROM THE CAPE OF GOOD HOPE BY THE LADY ANNE BARNARD, 1797-1801. Edited with memoir and brief notes by W. H. Wilkins, M.A. London : Smith, Elder and Co., 1901, pp. 316.

III.—A MAP OF AFRICA. Marcus Ward and Co.

Amongst the most important of the departments of work with which our POLYCLINIC concerns itself is the development of knowledge as to climate and the geographical and racial prevalence of disease. It is scarcely necessary to point out that in close connection with present conditions comes the history of the past. We have to ask what are the facts as regards diseases which are supposed to be new and as to those which have in some countries become extinct? The answers which we may find to questions on these subjects may, and probably will, prove of very great value in our decisions as to how best to deal with the problems of to-day. Nor is it needful to insist that the interests of British medicine are not now confined to our island home, but have become Imperial and world-wide. At the present South Africa claims the foremost place in the interested attention of Britain. We shall shortly be engaged in the colonisation of immense districts hitherto but little known to Europeans, and in the permanent government of an enormous territory which comprises various climates and different races. It is only right that the medical profession should zealously undertake its share in the endeavour to supply knowledge which shall enable those directly concerned in the government of South Africa to act wisely. We have already devoted considerable space to the consideration of the facts as to leprosy at the Cape and in the adjacent districts, but it will be necessary to recur again and again to it, for the subject is one of great and increasing interest. We have also referred repeatedly to the subject of syphilis, which is again one of pressing importance and presents for investigation some questions of great interest. These two maladies, although they afford perhaps some of the more definite problems, obviously constitute but a very small part of what concerns disease in South Africa. The facts as to the prevalence of the specific fevers, of diphtheria, of tuberculosis, of malaria, of dysentery and other maladies, are all of great importance.

Two of the works which we have placed at the head of this review concern the condition of Cape Colony a century ago, and are of value for our purposes chiefly as illustrating the habits of the community in reference to food, &c., at that time. Neither of them contain other than quite incidental allusions to disease. Both of them are works of considerable literary ability and valuable as historical documents. We shall, of course, deal with them only so far as the information they afford bears upon medical science.

Christian Frederick Damberger was a German (or Hollander) who, when young, in the year 1781, engaged himself to the Dutch East India Company and sailed for Batavia. In his outward voyage there was much illness on board, and before arrival at the Cape seven had died and one hundred and twenty-one were confined to their beds "by the scurvy or an inflammatory fever." At the Cape a physician boarded the ship and, declaring that they had a contagious disease on board, refused them permission to land, and for some days no boats were even allowed to visit the ship to supply fresh provisions. We are told that this health officer wished them to land "on Roggen Island, which is three leagues from the Cape," but it is not clear that they did so. This "Roggen Island" is, doubtless, the "Robben Island" of to-day, which has become notorious for its leper establishment. Thus, we learn that it was a quarantine station for Cape Town more than a century ago. After a few days' delay Damberger, who was ill of scurvy, was taken on shore and placed in hospital. He gives a graphic and by no means pleasant account of a Dutch Hospital of that date.

"The old sailors had often drawn a melancholy picture of the wretched attendance given in the hospitals of this place; but we found them not only in this, but in every other respect, more miserable than the description we had heard, or any idea we could form. On our arrival everyone received a coarse horse-rug swarming with vermin, and a wooden bed was assigned him on which lay a wretched mattress stuffed with sheep's wool."

"To every patient without distinction are allowed six ounces of bread, half-a-pound of meat, and half-a-kan (two quarts) of rice or barley-soup; the portions of those who are too ill to eat are taken by the attendants. Those who are in a state of extreme weakness live entirely on tea. When they recover so far as to require more nourishment and fresh air entirely to re-establish them, they are often wholly deprived of these advantages, which can only be obtained by those who are able to purchase their liberty by bribing the attendants. Their food is the same throughout the year, except that the meat is varied, being three days in a week mutton and the other four beef, which, however, is very bad and sometimes quite unfit for use, besides its black colour, arising from being dressed in iron pots.

"Three times a day the physicians, accompanied by two of the attendants, a surgeon, and two slaves carrying medicines, visit the sick and enquire into the state of their health. According to the account they give of themselves, various medicines are prescribed by the physicians, and administered by the surgeon; but this is done with the utmost irregularity, for the surgeon constantly attends with the physicians to receive their orders by word of mouth, and, in his hurry, either gives wrong medicines or none at all. When the physicians are gone, some of the patients, who have had no medicines, apply for them, and receive the same as their neighbours—scarcely ever those prescribed for them, but the first dose that comes to hand. In the evening a preacher of the Reformed Church reads one of the psalms, and sings a verse of a hymn, in each ward."

For some time our author was engaged as an assistant in a sort of hotel in Cape Town, and it was not until a year or two later that he commenced his travels. He had quarrelled with his employer, and was in some sense a runaway, and obliged to avoid the residences of planters. His route lay from Cape Town east on to Caffraria.

There is nothing in the character of this author's narrative of travel to lift it above the ordinary run as regards credibility. He is a somewhat egotistic man and probably like many others writes with a free pen on subjects concerning which there could be no possible contradiction. This admission concerns chiefly his own adventures and it need not invalidate his testimony as regards facts mentioned incidentally and some of these are of considerable value. From him we learn that rice and salt fish were at this early date in common use amongst the Hottentots who served as slave-labourers on the Dutch farms more or less remote from the coast. In reference to the subsequent spread of Leprosy this fact becomes very important and it is one which would not have been expected. The article of food most suspected by those who hold that leprosy is produced by food, is salted or dried fish when eaten without being properly cooked. Now whenever rice forms a principal article of diet there always arises a craving for some condiment such as salt-fish supplies. Thus in many parts of the east (China, India, the Malay Peninsula, &c.) where rice is the staple article of food there some form of preserved fish is also largely used, and this often at great distances from the sea. Now in the case of South Africa we have the well established fact that leprosy has slowly extended, and is still extending, into districts concerning which the evidence is well-nigh conclusive that it did not formerly exist. We have

also the further fact that the Dutch settlers at the Cape very early imported Malays to carry on a fish-curing trade at Cape Town. This establishment was in activity long prior to our author's travels, and some of his incidental remarks are valuable as proving that the article in question had already come into common use in inland farms. Within a few days' journey of Cape Town he writes :—

"On the 27th I arrived in the neighbourhood of Mr. Brand's estate, but kept myself concealed till night, when I went into the slaves' house to avoid being seen by the overseer, and desired the slaves not to mention my arrival because I intended to set off the next morning. I ate some rice and fish, but could not sleep, owing to my numerous cares."

Again, a few days later, he having travelled on foot a little distance further to the east, he writes, after having slept in the open—

"My clothes were wet with dew, and I was very cold, but set off, and after two hours came to the fields of a man named Mühlmann, where I met with his slaves, and asked them for something to eat: upon which two of them gave me their allowance of rice and fish, I gave each of them a Dutch gilder and proceeded on my way."

These statements are, it may be submitted, conclusive as to what were the ordinary articles of food in Dutch homesteads near Cape Town in the end of the eighteenth century. It is a mistake to suppose that milk, cheese, and the products of the chase were its principal ingredients. Already it had been found economical to import food in concentrated form from distant places, and rice and fish appear to have been ordinary articles. The statements quoted apply to the region near to Stellenbosch (or as our author writes it *Stielen'sbusch*), and it is precisely in this region that the earliest recorded cases of leprosy in Cape Colony occurred. Our author makes no mention of leprosy, and it probably was then—indeed, it still is so—a rare malady. Nor does he give us much more information as to details of diet, excepting that he records at several places that milk was scarce. It is important to note, however, that he makes no mention of either rice or dried fish after he had left the immediate vicinity of Cape Town.

We give here a facsimile reproduction of part of the map which Messrs. Longman, the publishers in 1801 of a translation of Damberger's work appended to it. On it is marked in dotted lines the route which he is supposed to have taken. The map was laid

down as regards South Africa on the authority of Forster and may be taken to represent the knowledge of the district and the topographical nomenclature of the time.



Our author's impressions of the Hottentot character and habits are given as follows:—

"The Hottentots are very filthy in their persons, being, perhaps, the laziest nation upon earth; besides which, in many places they have a want of water. They are so inactive, that the most fertile spots are suffered to lie uncultivated, though here and there a little Indian corn is seen. They chiefly employ themselves in breeding cattle and hunting; but to the latter they only recur when compelled by hunger and other provisions fail. They fish very little, though they might, without much trouble, especially in winter, catch a great quantity of fish. Nor are examples wanting that they had rather fast several days than thus easily procure themselves food. The company has made them repeated offers to give them nets, grain, &c., and to remove them to spots nearer the Cape; but these they never accept because they fear they shall be obliged to labour and fatigue themselves. They prefer living miserably in deserts, like their cattle; and through mere laziness, suffer themselves to be driven about, sometimes to the southward by the Caffres, and sometimes to the eastward by the Bushmen; though, when they become seriously enraged, their enemies soon learn what they can do; but their characteristic trait is, to take no care for the future" (page 58).

Travelling further eastwards, he came in contact with bushmen and Caffres, and at length reached Natal.

Amongst the Caffres we hear only of milk, mutton, millet, Indian corn and game.

He denies that circumcision was common among the Caffres, as had been asserted by Le Vaillant. The district which he recognises as Caffraria was far larger than that to which the name has subsequently been applied, and it extended much north of Natal. He insists that there were various tribes of Caffres, some at enmity with others, a statement since fully confirmed. At one place which it is

difficult to identify, but probably not far north of Natal, he records that he was given for breakfast milk<sup>1</sup> and a broiled fish, and adds that during the day he assisted in fishing, hunting, cutting up game, and making fishing nets. These statements have their value in connection with the *ore rotundo* assertion of some who declare that under no circumstances will Caffres eat fish. Not far from the same district he got tipsy—much to the delight of the natives—on a drink made from a kind of fruit “named gegahoguha, a sort of plum.” This drink was served to him by the girls in hollow gourds. These were the north Caffres, and they had a tradition that they had migrated from the north and driven the south Caffres further south. Circumcision was unknown amongst them. Speaking of the same people, he writes as to their pursuit of agriculture: “But the breeding of the cattle is more advantageous and costs very little labour, as may also be said of hunting and fishing.”

Leaving the Natal district (not then so named), our traveller proceeded northward and followed the Crocodile River (now Limpopo) into the interior. He subsequently traversed the whole of Africa to Morocco. He touched on the northern end of Lake Tanganika, and this lake is figured with fair accuracy in Messrs. Longman’s map. Here, however, we take leave of him, as our present concern is only with what he records as to the regions near to Cape Colony.

The book from which we have been quoting was published a century ago and was written ten years earlier still. It concerns a time when the Dutch were in possession of the Cape. The one which we now proceed to examine, although written only a few years later, is one of Messrs. Smith and Elder’s most recent publications. Its author, the Lady Anne Barnard, went to the Cape in 1797, her husband having received, through her influence, the appointment of Secretary to the Governor, Lord Macartney. She was a highly accomplished lady and had been on intimate terms of friendship with Henry Dundas, a

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<sup>1</sup>A curious instance of mistranslation occurs here. It is well known that the Caffres can make basketwork so close that it will hold fluids. Damberger writes that he had milk brought to him in very fine basketwork, which the translator, perhaps to heighten the wonder, gives as “a very fine latticework basket of milk.” Latticework is precisely what it could not possibly be.

member of the Pitt Ministry, and afterwards Lord Melville. She went out to take position as society leader in Cape Town, and as one who was likely to do something to break down the barriers which separated the Dutch and the English residents. In early life, when Lady Anne Lindsay, she had written the pathetic ballad of "Auld Robin Gray" and she had a warm heart and sympathetic manners. It might almost be said that part of her understanding with Mr. Dundas was that she should keep him well informed as to what was passing at the Cape. Hence these letters. Inasmuch as they are all addressed to one person and written with, to a certain extent, a definite object, they have less of variety in them than have the famous letters of Lady Mary Wortley Montagu, with which in other respects they might fairly be compared. Unfortunately also there are fewer of them. The little volume in which they are now for the first time published contains also a biography and some brief notes. It is a very interesting book and will be read from beginning to end by all who take it in hand. Lady Barnard resided only three years at Cape Town and never travelled far inland, and the information which she gives us concerns, therefore, chiefly that neighbourhood. She was, however, a keen observer and had good opportunities. In the year 1801, at the peace of Amiens, Cape Colony was again ceded to the Dutch, and the British staff resident there returned home. It was not till three years later (1806) that the colony, on a renewal of war, passed permanently into British hands. As regards Leprosy, we may say at once that Lady Anne never once mentions it. Her silence may be taken to prove that it was not then causing anxiety to the Cape Government and that it did not at that time in any way obtrude itself on public observation. Nor do we meet with much other notice of special diseases. She appears to have been much impressed with the good health of the Boers, their stature, large feet, and large families. The pride which the Boer women took in their children and the pity which they invariably expressed for herself, when she was obliged to admit that she had none, induced her to contemplate the artifice of telling them "that she had left four fine boys in England." The tendency of the women to fatten and to lose early whatever graces of form they had possessed when young drew her attention, as they have done that of most other observers. She makes, however, one statement which is

perhaps novel when she tells us that all Dutch women lose their front teeth at thirty, whilst in men the habit of smoking preserves them. Butcher's meat, both beef and mutton, she found plentiful and cheap, as also bread and Cape wine, but all other foods were dear, more especially vegetables and milk. Salt fish she does not once mention, but speaks in strong terms as to the excellence of much of the fresh fish which at different places came in her way.

That the climate or the diet, one or both, were not particularly favourable to English gout may be inferred from the fact that we find repeated mention of the sufferings of her friends Lord Macartney and Admiral Sir Hugh Christian. Both were old men, and both, no doubt, had inherited the malady, and had suffered before going to the Cape.

The following expresses her appreciation of the climate on short experience, but it was not fully confirmed subsequently.

"Here is a divine climate (at least I have found it so as yet), no fog, no damp, no variations to check the perspiration and fall on the lungs, but a clear, pure, yet not sharp air, full of health and exhilaration to the spirits."

Some of the most graphic of Lady Barnard's descriptions concern the habits and aspect of the natives. Of Hottentots and Kaffirs she saw many, but of the Bushmen only two. The latter had come up to Cape Town under Kaffir protection to pay their respects to the Governor. They are described as follows:—

"There is something singularly delicate in the make of the Bushman—his arms are so finely turned, and hands so small (one of the fingers of this one was withered off by the bite of a serpent). His wrist was as delicate as that of a lady, yet when he bent his bow it seemed to be strong, and the wildness of his figure was striking."

"His countenance was good humoured to the greatest degree, with more character in it than the Hottentot face, which has rarely more than gentleness to boast of. His hair was perfectly different from the hair of any other human creature I have seen, as it was like fringes of fine knotted black worsted, such knotting as old ladies do for beds."

A wish having been expressed to possess a lock of his hair, the man appeared to be flattered and readily sacrificed his queue, and his colleague also volunteered to submit to the scissors. Our authoress thus secured two trophies, but she admits that she did not afterwards like to show them to her friends. Next follow some facts as to the Kaffirs.

"I have had a visit at the Castle from one of the Kaffir chiefs, with his train of wives and dogs ; he was as fine a morsel of bronze as I ever saw, and there ought to have been a pair of them with candlesticks in their hands. Nothing could exceed the savages' notes, which accompanied their uncouth gestures in their warlike dances. I gave them many trifles, and the chief a cap, which pleased him so much that with the gallantry of nature he came forward, and on receiving it from the balcony in the courtyard, kissed my hand respectfully. I had prepared some dinner for them, but found they could eat nothing but beef or mutton ; pies, fowls, and still more particularly *fish*, they seemed to have no taste for ; indeed till they reached the Cape they had never seen a fish, hooks and lines being unknown to them, and the fish, therefore, in their rivers live unmolested by the wiles of creation's lords " (p. 79).

"A new Hottentot chief is arrived in Cape Town with a face of a different character from any I have seen before—finely made. Mr. Barnard is taking him to the Governor, who said he wished to receive him with 'some state,' and asked me what sort of cold collation he would like. I told him a good lump of boiled beef or mutton, and a little brandy, but begged his French cook might not put any of his *savoir faire* into the mess ; those people don't like anything high—they don't even eat salt if they can avoid it " (p. 289).

Lady Barnard, on the whole, liked the Hottentots, and says that they made a favourable impression upon her. The following quotation is of interest as showing her estimate of their rapidly decreasing numbers.

"I can perceive, however, from things in the newspapers and in letters from England, that there is a good deal of mistake about the number of Hottentots still existing in this country. I fancy that it is believed there are from 10,000 to 20,000, but from what I can learn from those qualified to judge, I doubt much if there are above 4,000. 5,000 was the number mentioned to me, and I am afraid they are diminished since. There is now no longer any fixed territory for these poor people, except the vicinity of the missionaries, where there are not above 800. The rest are all servants in the Colony, or live in small bands, establishing their kraals where they think they will be least annoyed, and ready to move off when they are so. The many other tribes which are to be found on piercing into this vast continent have each their fixed boundary, but the character of the tribes differs as much as their countenances and size do ; a Bushman being ingenious, subtle, and faithless as a Hottentot is the contrary. The Kaffirs are a superior race in size, force, and judgment, I fancy, to either " (p. 272).

The following, although in no way connected with medicine, is of such interest in reference to contemporaneous events, and we cannot forbear to quote it.

"First my dear friend, let me in three cheers express my joy on the late glorious event, which I daresay will form as bright a moment in history as England ever saw. Light gains double by shadow, and dark indeed was the shadow which preluded these victories. I see the new peer is to be Lord Nile, or Lord Something of the Nile. (I hope his eldest son won't be Baron Crocodile.) I should like to see a dozen more such creations."

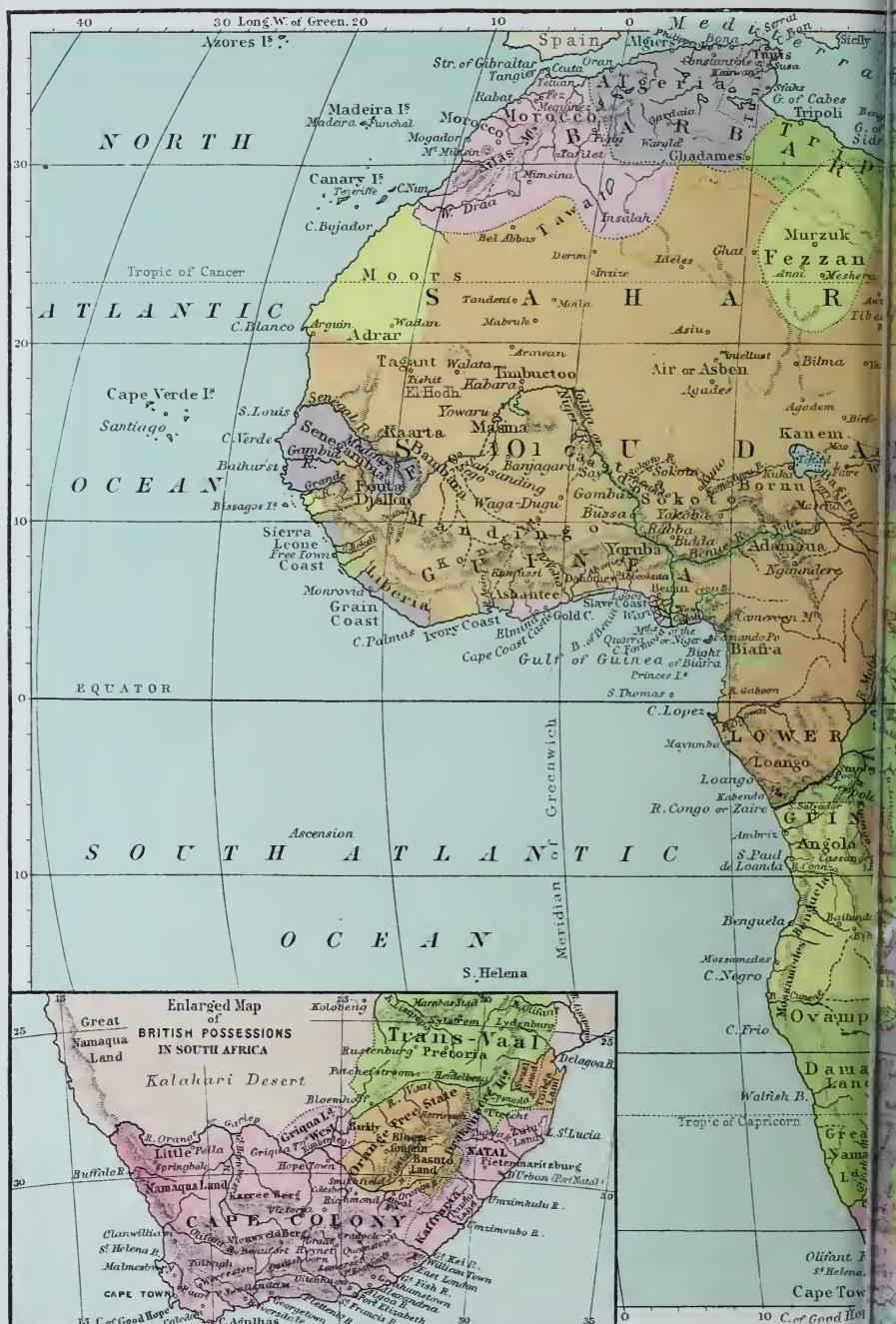
Our next and last quotation is, like the preceding, non-professional, but its importance as an item of testimony to the good effect of British rule is such, that patriotism, at the present juncture, forbids its omission.

"Can there be a greater proof of the flourishing condition of this Colony, compared to what it was formerly, than the complaint of the President of the Court of Justice, who says there is not above one bankruptcy in a hundred to what there used to be?—and even the *hangman* declares he has no longer anything to do. All this is a very flattering testimony in favour of English jurisdiction."

#### THE MAP OF AFRICA.

AMONGST the many minor offsets to the gigantic horrors of war is that we become familiar with geography. Nor is this an unimportant gain. Although in itself an attractive subject, geography, in its various departments, is yet one the study of which most men find it possible to defer, and they do defer it with a vengeance. Before the days even of the Raid the knowledge of the South African coast was probably sufficiently advanced in official circles to prevent the risk of a captain being asked to explain why, when ordered for Algoa Bay, he had landed his troops at Port Elizabeth, or that a fashionable society paper should inform its readers that the banks of the Orange River were the favoured resorts of Cape Town nursemaids. We had got beyond such blunders as these, yet there are none amongst us who do not stand indebted to what has followed on Kruger's invasion of Natal for at least four-fifths of the details as to South African geography with which we are at present familiar. The topographical geography which is learned by the diligent attempt to follow, with intelligence, the fortunes of an international war is, however, of a somewhat peculiar and fragmentary kind, and unless it be supplemented by wider study, it may result in only narrow conceptions of the facts. Still it has the great merit of compelling men to look at maps, and to look at them over and over again. This is in itself a great gain, for after all the visual memory of the lines of a map are essential for the foundation of almost all other kinds of geographical knowledge. It is, however, as we have already said, essential to those who desire such conceptions of fact as shall be useful to them in the concerns of peace, not to stop short with that which has been in a manner forced upon them during the turmoil of a war. Now, the medical geographer is a soldier whose









triumphs are the victories of peace. When the army departs it is for him to enter and to do his part in turning to their utmost account the results which the sword has won. It is for our statesmen and our generals to establish in South Africa the *Pax Britannica*; it is for us to make certain, so far as we can, that it is followed by the *Salus Britannica*, if by such an expression we may be allowed to denote the British standard of health.

If we are to fit ourselves as advisers in these matters we must begin with a sound basis of topographical knowledge. We therefore make no apology for placing before our readers, for the purpose of reference, a student's map of the continent of Africa.

#### *Some Geographical Memoranda.*

The Equator crosses Africa below the Gulf of Guinea and just as the continent is beginning to narrow down to its extremity at the Cape. Juba on the east and Cape Lopez on the west are on the Equatorial coast.

The Equator crosses the northern end of Lake Victoria Nyanza, runs close to Stanley Falls on the northern bend of the Congo and crosses the Congo again, much nearer the west coast, at Equatorville.

Most of the large lakes are south of the Equator:—Victoria Nyanza, Tanganika, Nyassa,<sup>1</sup> and Bangweolo.

The whole length of Madagascar extends from 13° to 25° south of the Equator and its lowest end is almost opposite Delagoa Bay.

Bloemfontein, Kimberley, and Natal are about as far south of the Equator as Cairo and the Canaries are north of it (30°), whilst Cape Town itself corresponds with Algeria.

The course and position of the great rivers should be clearly impressed upon the memory. The great Orange River, which has its mouth on the west coast, separates, by the first part of its inland course, the English Cape Colony from the German territory. Having divided not far west of Kimberley, its larger branch, now the Vaal, separates the Orange Colony from the Transvaal. The Drakensberg range of Mountains prevents it from completing its course right across the continent and converting Cape Colony into an island.

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<sup>1</sup> Do not confuse Nyanza with Nyassa. The prefix Victoria to the former should always be used. The word Nyanza simply means a lake or sea.

The river of next importance to the Orange is the Limpopo or Crocodile, which, having its mouths a little north of Delagoa Bay, constitutes in its course inland, curving north to the west, the boundary of the Transvaal Colony. Eight or nine degrees north of the Limpopo and the Transvaal we have running inland from the east and making a broad curve very much like that of the former, the famed Zambesi River. Its mouths and a certain part of its eastern trunk are in Mosambique, Portuguese territory, but inland it crosses Mashonaland and separates Matabeleland from Makolololand. It is the river which chiefly drains what is now known as Rhodesia. The great lakes are still further north, and from the southern extremity of Nyassa a channel finds its way into the Zambesi.

The reader is to remember that the Stanley falls are on the Congo (far north), whilst the Victoria falls are on the Zambesi, and are, as regards longitude, almost in the middle of South Africa.

*(To be continued.)*

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#### COLLEGE NOTES.

BY THE DEAN.

THE clinical lectures this month will be delivered by Mr. Priestley Smith, of Birmingham, on "The Treatment of Strabismus in Children" on the 10th, and by Dr. Playfair, Emeritus Professor of Obstetric Medicine at King's College, on "Chronic Invalidism in Women" on the 24th.

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ONLY one special course of lectures will be delivered during July, on Fridays the 5th, 12th and 19th, by Mr. James Cantlie, on "The Liver, its Anatomy and Surgery; and some of the more common hepatic ailments."

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THE College will be closed for the autumn vacation from Friday, the 26th of July, till Monday, the 2nd September.

\* \* \*

THE schedule of consultations and lectures for the September-December period of the year is now being arranged.

The special courses of lectures seem to have been much

appreciated and will therefore be continued on the present plan of two courses each month.

The Lectures Committee would be glad of suggestions as to these special courses, especially would it be useful to them to know from members what subjects are likely to be most attractive and to prove most generally useful.

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PROFESSOR SINCLAIR, of Manchester, changed the title of his lecture at the last moment, and instead of speaking on "Displacements of the Uterus," chose for the text of his discourse, "A Plea for Cæsarean Section, founded on the recent history of the operation and some personal experience." The facts connected with this operation are not as generally appreciated as they should be by the family practitioner into whose hands the suitable cases fall, and Professor Sinclair is doing a service to the profession by directing prominent attention to them. His own experience goes far to prove that the procedure might, advantageously to humanity, be more frequently resorted to than is now the case.

\* \* \*

IT has been more than once suggested by various members of the College that it would be a great advantage if it could be made known when important and rare cases are coming up for consultation, so that the literature of the subject might be looked into by those interested before such cases were seen and commented upon. This suggestion is entirely in accordance with what the Council have desired all along, but the difficulty has hitherto been that the Medical Superintendent has but seldom been previously notified of the cases he might expect. Reference has again and again been made to the difficulties he has experienced in having the patients so unequally distributed, and if the Recommendation Letters were more freely made use of, not only would that trouble be lessened, but previous announcement could then be made on the notice-boards of all the cases expected at each day's consultation. There can be no doubt that such a plan would be both convenient and satisfactory, but it should be extended to all cases and not only to those which are exceptional from their rarity. It will be carried out as a matter of routine whenever those who are either bringing or sending patients and who have the time and opportunity for

doing so get into the habit of supplying the Superintendent, a few days previously, with the requisite information.

\* \* \*

THE attendance on the Practical Classes, the Summer Term of which commenced on the 10th ultimo, has not improved. At a recent meeting of the Lecturers with the Lectures Committee, the position of these classes was fully considered, and, after some discussion it was unanimously agreed to recommend to the Council the adoption of a lower scale of fees.

The rate which the Council will be asked to authorise, in future, is to be one guinea for each class, and a composition fee of five guineas, which will confer the right of attendance upon all the classes of the practical course for a term. This ratio of payment is so small, that there can no longer be, if indeed there really ever was, any question as to the fee being prohibitive, and it is much to be hoped that greater advantage will be taken of the opportunities which these classes provide for detailed instruction in special subjects. The numbers will still be kept within such a compass as will ensure each student finding an opportunity for becoming personally familiar with the methods of examination, use of instruments of precision, &c., with which the class deals. Arrangements will also be made whereby duplicate classes will be held in any subject which attracts a larger number than a maximum of twelve.

\* \* \*

IN accordance with a previous resolution of Council, a condensed course of Practical Classes will be held during the month of September.

The dates are not yet fixed, but Captain Pinch is now engaged in arranging the details and the completed scheme will be published in the August number of the POLYCLINIC. The intention is to carry out the existing plan of classes exactly as now arranged, but instead of extending them over six weeks to compress them into half that time.

The same number of lectures will be given and the same amount of ground traversed, but use will be made of the forenoons and evenings instead of the afternoons only, so that work will be going on practically all day. The fees also will be the same as for the longer course.

The Council hope this arrangement may be a special convenience to provincial men and others, who, with only a short holiday or limited opportunity for absence from home, desire to make the most of their time. The first course in September is to be looked upon as experimental, but if it proves successful and the classes fill up well, others like it will be arranged for at suitable periods of the year.

Indeed, if the success were marked, the question would arise whether the present six weeks system would not be better entirely replaced by more frequent courses of only three weeks' duration.

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DURING the month of May twenty consultations were held, and one hundred and twenty-two patients came or were sent to the College for an opinion.

The total attendance of members for the month numbered 1,190.

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THE Medical Superintendent has begun the collection of pathological specimens with a view to the formation of a small museum. He will be very grateful if members will assist him by sending in morbid tissues or organs suitable for mounting and preservation.

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THE Hon. Librarian has pleasure in acknowledging further gifts of books from Dr. Henson, Mr. Reginald Harrison, Dr. Lichtenberg, Dr. Alex. Gibson, Dr. Ashburton Ramson, and Mr. James Berry.

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IT was intended to produce in the present issue of the POLYCLINIC a full report of the proceedings at the Dinner last month, but the editor finds that to carry out this plan would entail too large a demand upon his space. It has therefore been decided to publish the account of the Festival in pamphlet form, and the reporter's notes are now in the hands of the printer for that purpose. Members may have as many copies of this pamphlet as they wish by applying to Captain Pinch, and they will do a service to the College if they will distribute them widely among their influential and generous friends. Mr. Balfour's appeal cannot be too widely read, nor can it fail to convince those who do read it that, as an Institution, we have a substantial and commendable claim both on our own profession and on the charitable public.

THE financial outcome of the Dinner was less than might have been expected. With such a large number of guests there was a temptation to be perhaps over-sanguine as to results, but the feeling cannot be resisted, even now, that had every member of the College present done his best the golden issue would have been greater. This statement is accentuated by the fact that included in the sum-total were several very munificent donations. It seemed to be forgotten by many that the feast was provided more to raise money than to promote social intercourse, and that Mr. Balfour had done us the honour of coming to preside for the purpose of luring guineas into the Polyclinic exchequer, and not only to afford anyone who chose to do no more than buy a ticket, opportunity for listening to his eloquence. His masterly pleading ought to have produced a more generous all-round response, and especially from those who, being members, might be supposed to have the interests of the College more or less at heart.

After all the expenses are paid, the immediate net result of the Dinner will amount to about £1,300. We must live in hope that Mr. Balfour's words will yet fall upon productive ground, and that this sum will later on be largely added to.

There are many and important developments in the work of this College which are becoming essential if its course is to be progressive, but none of these can be entered upon without the possession of much more hard cash than we can at present boast of.

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#### CORRESPONDENCE AND ANSWERS.

From Boothroyd's "History of the Ancient Borough of Pontefract," 1807, p. 382.

##### *Lazar House.*

In the fourteenth of Edward I., 1286, Henry de Lacy built a Lazar House here, and dedicated it to St. Mary Magdalene. The order of St. Lazarus, of Jerusalem, seems to have been founded for the relief and support of lepers and impotent persons of the military order. Archbishop John Romain granted an indulgence to all those who contributed to the relief of the lepers therein. It appears probable that the hospital called Frank's Hospital is either the Lazar House or has been built on the site of it. The figure of a knight, cut in stone, in the wall, nearly as big as life, seems to justify this conclusion. The figure is now much defaced, the arms have been broken off, and the head nearly destroyed."

MORTALITY FROM PHthisis IN THE EIGHTEENTH CENTURY.—Dr. John Arbuthnot, who wrote his celebrated "Treatise on Ailments" in 1735, thus records his experience as to "consumption, pulmonary": "This disease makes up above a tenth part of all the Bills of Mortality about London. It is often the product of a scrofulous constitution or King's Evil, seldom invades after Thirty years of Age, may be prevented but seldom admits of any other than a palliative cure, and is generally incurable when hereditary, but easily so when it proceeds from an accidental cause." He adds: "The English consumptions, generally speaking, proceed from a scrofulous disposition."

\* \* \*

IN "The Bechuana of South Africa," by William Crisp, B.D., Archdeacon of Bloemfontein (S.P.C.K. about 1880), we find a reference to leprosy.

Apropos of visiting a poor leper girl, some 18 years of age, he adds: "This terrible disease finds many victims among the natives and half-castes of South Africa. Generally it first attacks the fingers and toes, beginning with sores which grow more and more virulent, until, joint by joint, these members become eaten away; but in its later stages it affects the face and other parts of the body. Apparently its victims do not suffer much pain, but the sadness which is always written on their faces marks their sense of the loathsome nature of the disease."

It is of interest to note that the expression of sadness described by the Archdeacon is often due to symmetrical paralysis of the facial muscles.

\* \* \*

LEPROSY IN JAPAN.—Leprosy is very prevalent in Japan, though not universally distributed. The following item in reference to fish consumption is of interest. Describing the tutelary deities of the oldest form of religious faith, Mr. Eden writes: "The God of Daily Food is personified as under the features of the patron of fishermen, Yebis, a disgraced brother of the sun, who reduced himself to the condition of a fisherman and vendor of fish—an article of food which stands in the same relation to the Japanese as bread does to the inhabitants of other countries."

\* \* \*

L.R.C.P.—The well-known extra-pharmacopœia of Martindale, of which a new (the tenth) edition has just appeared, will give you exactly the information you appear to want. It costs ten and ninepence, post free, and is to be had at 10, New Cavendish Street, or of Messrs. Lewis. It contains also Analytical Memoranda.

\* \* \*

CONTAGION OF SYPHILIS BY FLIES.—Some recent observers may have thought that in making the suggestion that flies are the means of spreading the contagion of Yaws they were more or less original. In Alibert we have the following statement (1814):—"La contagion du Pian est, à ce qu'on assure, singulièrement facilité par une espèce des mouches que l'on nomme mouches-frambœsia, et qui sont très-abondantes dans les pays chauds."

\* \* \*

ALIBERT, when he described his case of Pian Ruboïde thought that it was identical with Yaws. The following extract may not be without its interest for those who still think that "Sibbens" was identical with Yaws and that both are distinct from syphilis. Alibert wrote in 1814: "C'est sans raison que plusieurs Nosologists ont voulu établir des différences entre le Pian d'Amérique proprement dit, et l'Yaws endémique dans la Guinéé. Ces maladies sont absolument identiques et ne sont que légèrement modifiées par les influences du climat. C'est au Pian ruboïde qu'il faut parcellement rapportez l'affection connue sous le nom de *Sibbens* ou *Sirvens*, apportée en Ecosse dan le temps de Cromwell par les soldats qu'il mit en garnison."—Page 155 of "Alibert's Atlas."

# MEDICAL GRADUATES' COLLEGE & POLYCLINIC,

## 22, CHENIES STREET, GOWER STREET, W.C

### SCHEDULE OF CONSULTATIONS AND LECTURES

From APRIL to JULY, 1901.

Consultations at 4 p.m.

MONDAYS. (Skin)	TUESDAYS. (Medical)	WEDNESDAYS. (Surgical)	THURSDAYS. (Surgical)	FRIDAYS. (Eye, Ear, Nose, and Throat)
April 1 Mr. Malcolm Morris	April 2 Dr. Guthrie Rankin	April 3 Mr. J. Cantlie	April 4 Mr. Hutchinson	April 5 <i>Good Friday.</i>
April 8 <i>Easter Monday</i>	April 9 Dr. Harry Campbell	April 10 Mr. J. Berry	April 11 Mr. Hutchinson	April 12 Dr. Dundas Grant
April 15 Dr. A. Whitfield	April 16 Dr. Seymour Taylor	April 17 Mr. P. W. De Santti	April 18 Mr. Hutchinson	April 19 Mr. Ernest Clarke
April 22 Dr. J. Galloway.	April 23 Sir Wm. Broadbent	April 24 Mr. Reg. Harrison	April 25 Mr. Hutchinson	April 26 Dr. St. Clair Thomson
April 29 Mr. Malcolm Morris	April 30 Dr. Theo. Williams	May 1 Conversazione	May 2 Mr. Hutchinson	May 3 Mr. R. Lake
May 6 Dr. T Colcott Fox	May 7 Dr. C. O. Hawthorne	May 8 Mr. P. J. Freyer	May 9 Mr. Hutchinson	May 10 Mr. Marcus Gunn
May 13 Dr. J. J. Pringle	May 14 Dr. James Taylor	May 15 Mr. A. H. Tubby	May 16 Mr. Hutchinson	May 17 Dr. Herbert Tilley
May 20 Mr. Malcolm Morris	May 21 Dr. R. L. Bowles	May 22 Mr. Reg. Harrison	May 23 Mr. Hutchinson	May 24 Dr. Dundas Grant
May 27 <i>Whit Monday</i>	May 28 Dr. Harry Campbell	May 29 Mr. W.H.A. Jacobson	May 30 Mr. Hutchinson	May 31 Mr. N. MacLehose
June 3 Dr. J. F. Payne	June 4 Dr. W. Ewart	June 5 Mr. E. W. Roughton	June 6 Mr. Hutchinson	June 7 Dr. Herbert Tilley
June 10 Dr. A. Whitfield	June 11 Dr. James Taylor	June 12 Mr. J. Berry	June 13 Mr. Hutchinson	June 14 Mr. R. Lake
June 17 Dr. J. F. Payne	June 18 Sir Wm. Broadbent	June 19 Mr. Johnson Smith	June 20 Mr. Hutchinson	June 21 Mr. Treacher Collins
June 24. Mr. Malcolm Morris	June 25 Dr. Theo. Williams	June 26 Mr. P. J. Freyer	June 27 Mr. Hutchinson	June 28 Dr. St. Clair Thomson
July 1 Dr. T. Colcott Fox	July 2 Dr. Guthrie Rankin	July 3 Mr. W.H.A. Jacobson	July 4 Mr. Hutchinson	July 5 Dr. Dundas Grant
July 8 Dr. Jas. Galloway	July 9 Dr. W. Ewart	July 10 Mr. J. Cantlie	July 11 Mr. Hutchinson	July 12 Mr. Work Dodd
July 15 Dr. A. Whitfield	July 16 Dr. J. E. Squire	July 17 Mr. Johnson Smith	July 18 Mr. Hutchinson	July 19 Dr. St. Clair Thomson
July 22 Mr. Hutchinson	July 23 Dr. Seymour Taylor	July 24 Mr. P. W. De Santti	July 25 Mr. Hutchinson	July 26 <i>College closes</i>

### Clinical Lectures at 5.15 p.m.

1901.

- April 10th—Sir T. LAUDER BRUNTON, M.D., LL.D.  
 April 24th—HOWARD MARSH, Esq., F.R.C.S.  
 May 15th—Prof. CLIFFORD ALBUTT, M.D., LL.D.,  
     of Cambridge.  
 May 29th—GEORGE A. GIFSON, Esq., M.D., F.R.C.P.,  
     of Edinburgh.  
 June 12th—C. THEODORE WILLIAMS, Esq.,  
     M.D., F.R.C.P.  
 June 26th—Prof. W. J. SINCLAIR, M.D., M.R.C.P.,  
     of Manchester.  
 July 10th—PRIESTLEY SMITH, Esq., M.R.C.S.,  
     of Birmingham.  
 July 24th—W. S. PLAYFAIR, Esq., M.D., LL.D.

### Special Courses of Lectures at 5.15 p.m.

- 1901.
- April 15th, 22nd, 29th—Mr. W. MCADAM ECCLES,  
     “Hernia, and its treatment by Trusses.”  
 April 19th, 26th, and May 3rd—Dr. HERBERT TILLEY,  
     “Some important diseases of the Ear, Nose, and  
     Throat.”  
 May 6th, 13th, 20th—Dr. W. J. GOW, “Uterine dis-  
     placements, and some other common gynaecological  
     disorders.”  
 May 10th, 17th, 24th—Dr. JAMES TAYLOR, “Some  
     forms of Paralysis in children and young adults.”  
 June 3rd, 10th, 17th—Dr. SEYMOUR TAYLOR, “The  
     Surface Anatomy of the Chest and Abdomen.”  
 June 14th, 21st, 28th—Dr. TANNER HEWLETT, “Serum  
     Therapy.”  
 June 24th, July 1st, 8th—Mr. A. CARLESS, “The Sur-  
     gery of the Stomach.”  
 July 5th, 12th, 19th—Mr. JAMES CANTLIE, “The Liver,  
     its Anatomy and Surgery; and some of the more  
     common hepatic ailments.”

GUTHRIE RANKIN, M.D., Dean.

A. E. HAYWARD PINCH, F.R.C.S., Medical Superintendent.

# THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES  
COLLEGE, LONDON.

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VOL. V., No. 2.—AUGUST, 1901.

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## BOVINE TUBERCULOSIS.

THE truth of the saying that the progress of truth, although ever upward, is in a spiral curve, has seldom had a better illustration than in Professor's Koch's announcement that bovine tuberculosis is not communicable to man. It is one of those judicious steps backwards which are of incomparably greater value than the headlong rushes to the front which enthusiasts are so apt to make. It may be that in reference to some other items of the widely branching creed which has, with so much confidence, been inferentially based on the discovery of the tubercle bacillus, other recantations will have to follow. It is to be noted that Koch's announcement is of importance chiefly as coming from him, and that it is not novel. That it should have excited so much surprise as it appears to have done in medical circles is, indeed, somewhat remarkable. In our own pages incredulity has, we believe, been more than once timidly hinted at. Others have been bolder, and amongst them may be counted Professor McFadyean, of the Veterinary College, who as long ago as 1898 wrote that recent investigations had "tended to show that the connection between human and bovine tuberculosis is not so intimate or so important as supposed." In the able "Studies in Human and Comparative Pathology" by Dr. Woods Hutchinson, recently published, we read:—"We are also, I think, justified in taking a somewhat more cheerful view than that usually held at present as to the actual risk of com-

munication of tubercle from animals to our own species. Evidence is slowly accumulating which we think would justify us in holding that there is at least a possibility of doubt on this question." And again :—" Certainly the most careful researches which have yet been carried out to determine this particular point—those of Dr. Theobald Smith—have led him to incline decidedly to the conclusion that the bacilli are not readily transferable."

The question is, however, one of supreme importance, and although we might rejoice in the permission to again let our children drink new milk, yet we must not assume that it is settled one way or the other. The facts as to the possible latency of the bacillus through long periods of time, have to be reckoned with ; so also those which suggest that the bacillus is well-nigh ubiquitous, but delays its manifestation of activity until some injury, or perhaps some article of food, excites its energies. These facts have to be investigated, not alone in respect to tuberculosis, but also as to its congener, leprosy. In both these diseases the general mass of circumstantial evidence would seem to suggest that articles of food must be of great importance to their production. The inference, however, that the suspected food necessarily conveys the bacillus is possibly premature. It may be that it only feeds it. That leprosy may manifest itself for the first time twenty years after its subject has left the leprosy district, where he doubtless obtained its germs, is a fact which the cautious student of tuberculosis will do well to keep in mind.

The picture of bovine tuberculosis which alarms the mind of the public, and possibly of some in our own profession, is probably painted in colours far darker than the facts warrant. It would appear to be imagined that lucre-loving farmers continue to milk emaciated, cough-tormented animals, with their udders covered with sores. As a matter of fact, anything which can by possibility be diagnosed as tubercle of the udder is exceedingly rare. When we are told that 50 or 70 per cent. of the cows in a given dairy have reacted to the tuberculin test, it is to be understood that very probably not one of them all appeared to their owner to be in the least ill. The fact that the large majority of the cows kept in cities as milk-producers are fattened and sent to the butcher when their milk fails, speaks for itself. Since they are still capable of fattening

they cannot be supposed to be "tuberculous" to any serious extent. In truth, the presence of tubercle bacilli in a cow or ox often exercises no appreciable influence on the animal's health. Extensive tubercular deposits in mediastinal glands, and even in the lungs, have been found in animals slaughtered as fine specimens of Christmas beef. Nothing would have been more easy than by crude legislation on this subject to very seriously interfere with an occupation which is already sufficiently embarrassed, and at the same time to injuriously diminish the supply of milk and meat to the public. Of such legislation there is now much less risk than there was before Professor Koch made his candid retractation.

J. H.

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#### THE CHIGOE IN AFRICA.

AT one of our recent Demonstrations some specimens of the cyst-like formations caused by the "Jigger flea" were shown. They were from Pemba (Zanzibar), and had been brought over by a lady missionary, who had trained herself to expertness in their extraction. They look like little fibrous bags about as big as peas, and are placed immediately under a layer of epidermis. Their extraction is to be effected much in the same way that the buttons of *molluscum contagiosum* are removed. The epidermis must be freely cut through all round the circumference of the little cyst, and the latter must then be most carefully taken out. It is very important to remove it whole, as if any part is left, a troublesome sore may result. The cyst consists of the female—probably dead—and her eggs, and if any of the latter are left to hatch, much pain and disability will ensue. Our informant stated that the disease is now very common in Pemba, and that a not unimportant part of mission-work consists in teaching the natives how to deal with it. The occasion elicited from Sir William Kynsey the information that the Jigger is not as yet known in Ceylon. It is a curious fact in the natural history of this insect, that it is believed to be of recent importation into Africa—its native home being South America. In Africa, however, it has spread so rapidly that it has become a very serious plague. Sir Henry Colville, in a recent article on Uganda, speaks of it "as perhaps the greatest curse of the country, though (if care be taken) a minor

one"; and adds that "it has maimed whole populations." After saying that a man tried before him for the murder of his wife admitted the fact, but alleged in excuse that she was terribly infested with Jiggers, he concludes his statements by a doleful foreboding:—"I have no wish to be a prophet of evil, but it seems to me very probable that the Jigger will be the curse of Africa. Having made his way half across the continent, I can see no reason why he should not overrun the whole of it, unless science can find some means of stopping his progress."

At the time when Sir Henry wrote the Chigoe had reached Uganda, which, as a glance at the map (see Unyoro, lat.  $1^{\circ}$  N.) will show, is almost in the middle of the continent. Since then, as our specimens prove, the flea has fulfilled his prophecy, and reached the east coast.

Since writing the above, we have been favoured by Dr. Moffat (a grandson of the missionary) with the following particulars as to the Jigger in Uganda. Dr. Moffat had resided in that country as principal medical officer for some years. The Jigger had, he said, not been known until recent years. It had travelled across the continent from West to East, and Emin Pasha's expedition was credited with having completed its line of communication. Dr. Moffat told us that he had known many instances in which digits had been lost by the inflammation caused, and in some instances even an entire foot. It is not by any means confined to the human skin, but may live, and probably breed, in sand and in floors of houses. In such situations it often exists in countless numbers. It multiplies with marvellous rapidity and travels fast. It exactly resembles a small flea, and can jump like one. In penetrating the skin it causes no pain or irritation, but a few hours after it has embedded itself, intolerable itching attended by burning pain is caused. Dr. Moffat is of opinion that in Uganda the Jiggers are becoming already less virulent in their effects than they were when first introduced. He did not know of any remedy by which they might be killed, and held that prompt extraction was the only measure. Various substances might be used to smear the hands and feet to prevent its attacks.

As yet the Jigger has not reached Madagascar or India, nor, we believe, Arabia. It is, however, much to be feared that we shall

soon hear of it in all these places. Since its chief means of transit is in the human skin or clothing, we have another instance of the dangers, as regards the propagation of disease, which modern facilities for locomotion entail. Although, after all, only a flea, its effects are, as we have stated above, sufficiently serious to make the study of the means for its exclusion well worthy the careful attention of medical observers.

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### OUR INTEREST IN LEPROSY.

SOME of our readers may perhaps have thought that we have allowed rather undue space to the subject of Leprosy in the pages of the POLYCLINIC. It is not perhaps generally known that in some sense our College is the successor to the "Prince of Wales' Committee on Leprosy." From the representatives of that committee the Polyclinic, at the suggestion of Sir Joseph Fayerer and with the concurrence of his co-trustees, received the balance of what remained of the fund collected by that committee. This valuable donation was made on the understanding that special attention should be given to the subject. Hence in part our zeal. A yet more cogent motive is, however, supplied by the importance and interest of the disease itself. Next to tuberculosis and syphilis, it probably stands as the malady the elucidation of which would effect most for the happiness of the human family. There now exists a special journal devoted to it under the title of *Lepra*, and very ably edited by Professor Neisser, of Breslau and his coadjutor, Dr. Ehlers, of Copenhagen. In this international journal several of the articles which have appeared in the POLYCLINIC have been reprinted without abridgment.

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### GOUT AND RHEUMATISM.

WITHOUT doubt our opinions and creeds are much modified by differences in mental bias. Some of us are skilled in detecting lines of separation, and love to construct species and to assign data of distinction. Others delight to discover proofs of unity and to trace

relationships where they might have been least suspected. In the pursuit of truth in medical matters there is room for the indulgence of both proclivities, and both are useful. The one tends to give precision to our facts and to effect a more or less orderly arrangement of them, whilst the other helps us to the formation of those broad general principles which are fundamental to all progress. It was well remarked by a very liberal theologian that the assignment of mankind to either misery or blessedness seemed to him a too abrupt division. Whilst many were certainly fit for heaven, and a few perhaps for hell, the great majority would, he feared, "fail to secure a settlement." It is just so in endeavouring to group our clinical facts. If we adopt precise definitions and mark out species with accuracy, not a few of our cases fail to obtain a home.

The very obvious thoughts which have been just expressed seem to have an especial fitness to the present state of opinions as regards gout and rheumatism. Whilst some are determined not only to abruptly separate these maladies but to find specific differences between many of the forms of arthritic disease usually classed under the latter name, others are equally zealous to connect them all into one great family group. To assert that rheumatic fever is a fever in a specific sense, having no relation to other forms of arthritis, is to the latter a heresy as grievous as to argue that podagra and chalk-stones are the only legitimate offspring of "true gout." For them these various types of disease are with regard to cause constantly mixing themselves together and forming in their various combinations the several groups which, whilst by no means specifically distinct, it is convenient to recognise by different names. They hold that there are on all hands ill-defined cases—cases which under a theory of unity in their nature are easily placed, but which under any possible system of specific classification would fail to find a settlement.

The bond of connection for those who believe in the unity of the arthritic diathesis is hereditary transmission. Under this influence they believe that tissue proclivities and special peculiarities of organisation or of functional tendency are transmitted from one generation to another, receiving from each such modifications as the union of two different parents and the habits of the individual may be able to confer.

## SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

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### ABSTRACT OF A LECTURE ON CÆSAREAN SECTION.

BY PROFESSOR W. J. SINCLAIR, M.D., M.R.C.P.

*Owens College, Manchester.*

THE first part of Professor Sinclair's lecture was occupied by a sketch of the history of the operation. Allusion was made to various traditional and authenticated accounts of its performance, and a description was given of the improvements in technique which have been effected in recent years. The appalling mortality of the earlier records was explained as the result for the most part of sepsis, and the favourable statistics of to-day were credited to a recognition of the value of asepsis and to the performance of the operation, not as a *denier ressort*, but as a matter of election. It was argued that the operation carried with it no inherent mortality and that in uncomplicated cases it was among the easiest proceedings of abdominal surgery. In all suitable cases therefore it ought to be performed rather than resort to measures involving the death of the child. The statistics of experienced operators showed a mortality in suitable cases of 4·5 per cent., and even taking the cases without selection and including those in which there were serious complication, the death-rate has not more than 13 per cent. Further, a large proportion of the fatal cases were due to postponement of the operation until the woman was exhausted by prolonged labour and by various injudicious attempts to effect delivery. When from the history of repeated craniotomies, or of premature labours induced of necessity, or from the facts elicited by pelvic examination, it is certain that a pregnant woman cannot be delivered of a living

child, it ought to be promptly recognised that Cæsarean section is indicated and preparations should be made accordingly. Professor Sinclair expressed the belief that the operation in uncomplicated cases could be readily undertaken by the general practitioner and he expected to see this anticipation realised. He claimed the right to refuse craniotomy and argued that medical opinion should demand that a woman should submit herself to Cæsarean section rather than be offered the choice of an operation that involved the destruction of a living child.

Regarding the operation itself the time for its performance is before labour has begun, which necessarily means that the nature and demands of the case have been recognised at a relatively early date. Chloroform was defined as far superior to ether as an anaesthetic in these cases. In this connection Professor Sinclair related a recent experience in which he had successfully operated without a general anaesthetic, the patient being entirely kept free from pain by the introduction of cocaine into the space. The existence of bronchitis and a dilated heart appear to forbid both ether and chloroform. In the actual technique of the operation it was stated that there was not much that could be described as essential. A mesial abdominal incision was advocated and an inexperienced operator, at least, would be well advised to draw the uterus well forward through this. The essential demand of the uterine incision was to make a clean aseptic wound and the discussion of its direction was a fight about the non-essential; in size it should be sufficiently large to avoid tearing and bruising the uterine tissue in the extraction of the foetus. Various other details were explained and allusion was made to the general conditions which may complicate the operation.

In conclusion it was strongly urged that even in recent years many lives were lost by a non-recognition of the necessity of Cæsarean section at a date when the woman was yet in a state favourable for operation. For further improvement in the statistics it is essential that the nature of such cases should be diagnosed before labour has commenced, so that the operation may be undertaken under the best possible circumstances and not after repeated and violent attempts have been made to effect delivery by forceps, turning, and other methods.

## EXTRACTS FROM CLINICAL LECTURES.

BY JONATHAN HUTCHINSON.

## I.—A CASE OF FATAL FRAMBŒSIAL SYPHILIS IN AN ENGLISH-WOMAN.

IN this case (which is that referred to at page 267) a secondary syphilitic eruption in an Englishwoman exactly resembled that of the so-called “yaws.”

The patient was an unmarried barmaid. She was first seen by me on March 4 when she brought a letter from her medical attendant. Her illness was said to have begun about Christmas, when a miscarriage had been suspected. A very troublesome eruption had been the chief condition present. It affected her face more severely than other parts. No recent exposure to sexual risk was admitted by the patient, but she acknowledged having borne a child some years ago. When she took up the thick veil by which she was protected, her whole face was seen to be covered with thick heaped-up crusts. Some of these were as large as cherries, and others not bigger than peas. They were of a dirty yellow colour, and not in the least limpet-shell like, but rather of the bee-hive form. They were especially large on her upper lip and some other parts of her cheeks, but were present on the forehead and all exposed parts. On her arms, legs and thighs, placed with accurate symmetry, were other spots on which the crusts were much smaller, and some of which were of the varioloid type. There were a few also on the trunk, but the eruption was only sparing excepting on the face. I made an examination of the genitals and found traces of recent sores and some enlargement of inguinal glands; there was however no tendency to condylomata. The patient was emaciated and her skin very pale. There was no trace of sores in the throat or mouth. She had already taken mercury in small doses. There was a history that she had shown symptoms of right hemiplegia, but these had quite passed away.

I prescribed mercury. On March 20 she came to me (at my house) for a second time. Her gums were decidedly touched, and

she had also suffered from diarrhoea. Her eruption was very much better. On the limbs and trunk the varioloid pustules had disappeared, and many of the crusts on the face had fallen, leaving only stains. On account of the diarrhoea and ptyalism we were now obliged to suspend the mercury. Chlorate of potash and tonics were ordered.

It was on March 27 that this patient attended at the Polyclinic.

She attended at my request and for the express object that I might demonstrate that her eruption, which consisted of soft granulation masses covered thickly with a pus-crust, differed in no respect from that which is claimed to be characteristic of tropical yaws. Had I known how ill she had become I should not have allowed her to attend.

She was at the time so feeble that I did not allow her to stay more than a few minutes in the consultation room. Her friends were enjoined to take her home and get her to bed as soon as possible. All present, had however, the opportunity for observing that her face was covered with crusts and the stains of patches from which crusts had fallen, the crusts were of a dirty yellow colour and concealed masses of soft granulation. They were most abundant on the lower part of the face and had already fallen from the forehead. There was no sore throat, and on the trunk and limbs the eruption had to a large extent disappeared. No mercury had been given for a fortnight. Amongst those who saw the patient was Mr. Finucane (of Fiji), who stated that the conditions were exactly like those of the disease known in Fiji as "yaws."

I did not myself see this patient again, but about a fortnight later I heard from Dr. D., of P., that she had died. Dr. D. wrote me that the death had been sudden and somewhat unexpected, but I was not surprised to hear of it, for from the first her condition of debility had been extreme. The eruption had yielded to the mercurial treatment (which had been resumed), but the debility, weakness, and anaemia had increased. There had been only slight ptyalism, but diarrhoea had been troublesome for some days.

In commenting on the case I pointed out that it was an instance of an extremely rare event;—a death during the secondary stage of syphilis. I had, I remarked, seen more than a very few in which death had been threatened, but I did not remember any one in which

it had actually occurred. As to the precise cause of death we were still a little in the dark, but the patient's condition of anaemia had been such that we need not seek far for it. Probably it had been due to cardiac syncope from exhaustion. As regards the peculiar character of her eruption I pointed out that it was a most severe one. Next perhaps to the bullous (syphilitic pemphigus) the varioloid and framboesial forms are indicative of the most dangerous types of syphilis. This, at any rate, has been my experience of them in English patients. Those who had observed yaws (which I regard as framboesial syphilis) in its native haunts give us varying reports. Some speak of it as usually a mild disease, but the majority admit that it is not infrequently fatal. It is to be noted that this patient never had any sore throat or other affection of the mucous membranes. This, I think, is the rule when the disease falls with especial severity upon the skin, and we may probably assume that it is one of the negations which has, with some observers, strengthened the opinion that yaws and syphilis are distinct maladies. As a matter of fact, however, sore throat is often omitted from the *rôle* of syphilitic phenomena.

## II.—DERMATOLYSIS IN ASSOCIATION WITH MOLLUSCUM FIBROSUM.

The man now before us, Gentlemen, offers such a close resemblance to a portrait which I already possess, that I find it difficult to believe his statement that he has never been photographed. His case, as you see, is one of pendulous dermatolysis. Huge saddle-bags of over-grown skin cover his chest and shoulder on the right side. You might lift the one from his chest and throw it over his shoulder, and the one from his shoulder and throw it upon his chest. We may take it, therefore, that the condition took its origin on the top, nearly in the middle, and that it has slowly progressed downwards, both behind and in front. For, let us note, these extraordinary conditions are always of slow production. A bit of abnormal tissue—a mole, in fact—is always present at birth, but it may be very inconspicuous, and conditions such as we now see result from its slow growth. In the present instance the man tells us that he had nothing when a child, but in this he is of course in error. You will notice that in addition to his more conspicuous abnormality, he has



*Portrait of a man, the subject of pendulous Dermatolysis (front view).*

on various parts, arms, chest, &c., a number of little subcutaneous and cutaneous tumours, which are of the nature of what we know as molluscum fibrosum. This is according to rule, for pendulous



*Back view of the same man.*

dermatolysis and molluscum fibrosum are almost always met with in association. I commented upon the law which underlies this association, as some may remember in a clinical lecture<sup>1</sup> delivered not long

<sup>1</sup> See POLYCLINIC for July last, p. 12.

ago. We may note with interest that the hypertrophic condition of the skin, in this case, has been in part, the result of mechanical laws. As soon as a fold of skin becomes pendulous it tends to swell and the oedema makes it heavy and its weight increases its pendulousness. The lowest parts of what I have likened to saddle-bags are very much thicker than the rest. The subcutaneous tissue is in them in a state of solid oedema and this constant saturation with fluid containing living cells favours over-growth. It is a parallel condition to that which occurs in cases of what is known as smooth elephantiasis and which affects as is well known, parts which are hydrostatically at disadvantage, the legs, the scrotum, &c. In elephantiasis, however, attacks of erysipelatoid inflammation precede the oedema and by frequent recurrence, aggravate it. In dermatolysis it is the pendulous condition alone with which we have to deal. There is but little risk of attacks of inflammation and no tendency to involve the adjacent skin excepting by displacement consequent upon traction. You will see that the skin which is concealed under these huge pendulous folds is quite healthy. Nor is there the slightest tendency to anything like malignant growth.

We come now to treatment. It would have been far better for our patient if the hypertrophied portion of skin had been excised when he was a boy, when it was just setting out on its travels. The operation would then have been insignificant. It would now be an extensive affair. Yet it would probably be worth his while to have it done for although the growths are not on a part exposed to view they must be a great inconvenience to him in his work. I should urge an operation upon him with more confidence if I did not remember that in one of the cases most like his, death from erysipelas followed the excision. This was before the days of aseptic surgery, but I fear we cannot feel that even under the latter the risk of erysipelas is wholly done away with. It is probably especially great in cases in which the skin is extensively involved.

## NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

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### MEDICAL CASES.

BY DR. WM. EWART.

*Tuesday, June 4, 1901.*

CLINICAL Demonstrations were given on several cases, including a case of splenic anaemia of at least ten years' standing, in a man aged 22.

A case was also exhibited in which localised tenderness of the left costal arch and of the cartilaginous tip of the eleventh and twelfth ribs were associated with a neurotic tendency and with a painful affection of the diaphragm. The subject of costal acro-chondralgia was discussed at some length.

### II.—*Cases illustrating the Treatment of Bronchiectasis and of Chronic Bronchial Affections by Posture and by Respiratory Exercises.*

The two cases exhibited were instances of long neglected chronic bronchial affection. In both the relief to the spasmodic cough and the cessation of the gushlike expectoration were marked, and the method had fulfilled its object, that of keeping the bronchial tubes free from accumulation.

Had the patients been treated from the first after this plan their bronchiectasis would not have reached the stage of fibrosis, which is probably incurable, and conceivably they might have been cured.

*Prophylaxis* is thus within the province of this treatment. Since we do not know how to identify quite early the tendency to bronchiectasis, we might wisely treat children suffering from chronic bronchitis as though they belonged to this class.

Indeed the benefits of the treatment are not to be confined to cases of bronchial dilatation or of excavation needing to be kept empty and dry, but may be obtained in many cases of catarrh with tenacious expectoration, the relief of which is rendered more difficult by the patient's misguided endeavour to cough up the expectoration in the sitting posture.

*The continuous postural method*, which I have adopted, must be more efficacious than the intermittent prone posture with the head inclined lower than the feet for periods of half-an-hour or an hour twice daily, as recommended by Quincke, who had already written on this subject in 1898 (*Zeitsch. fur Kkflage*. August, 1898, p. 525; cf. also O. Jacobson, *Berl. Klin. Woch.*, October 8, 1900). This is an improvement upon the practice of leaning over the edge of the bed to empty a basic vomica, which had formerly been sometimes recommended in spite of its risks.

I agree with Quincke in recognising in this method: (1) the mechanical effect of gravitation, (2) the effect of a stimulation of more excitable mucous surfaces by the gradual rise of the expectoration, (3) the tendency to re-expansion of the alveoli, and (4) the expiratory advantage due to the diaphragm being pushed up by the weight of the viscera.

The dangers arising from retention and sepsis are guarded against if the bronchial relief is complete and continuous. This enables us to proceed with the respiratory exercises, which are intended to reclaim the curable portions of the damaged lung—with great promise of success in youthful subjects.

The cases illustrate most strikingly the value of this treatment (cf. *Lancet*, July 11, 1901), which, when it can be adopted, is of much service in bronchial affections attended with difficult expectoration, but is nowhere more useful than in bronchiectasis. In both cases symptoms of the latter had existed for many years from early adolescence, and had received no treatment whatever. The younger patient, aged 20, had improved for a while under ordinary treatment, including the use of the respiratory jacket, but was re-admitted into the hospital with a severe feverish attack, fetid expectoration, paroxysmal cough, night sweats, and a hectic temperature—symptoms which ordinary measures failed to relieve. Whilst watching the patient during a severe paroxysm of cough in

the orthopnoëic position, I realised that the practical indication had not been fulfilled, and the patient being made to lie down, the foot of the bed was raised to the level of my shoulder, and subsequently kept raised to the height of fourteen inches. This simple procedure had the happiest effect, and allayed the paroxysms of cough, whilst greatly facilitating the rise of the secretion.

The temperature from that day ceased to rise in the evening and remained permanently normal ; the night sweats disappeared, and a general improvement was manifest. After being allowed to get up, the patient continued to sleep with the foot of the bed raised, and does so still. Since that day she has never had the gushes of expectoration peculiar to bronchiectasis. Nevertheless, during the winter she again suffered from catarrh and from fetid secretion. This would show that the postural treatment alone does not avail to prevent foetor, and I became more and more impressed with the belief, which I have expressed on previous occasions, that the bronchial secretion may become infected from the mouth. She was re-admitted on March 26, 1901, and on this occasion several carious stumps were removed. She made further progress under the joint influence of postural treatment, of respiratory exercises—which were now instituted in her case—and of ichthyol externally. She also had six intravenous injections of protargol, without any striking result. In addition to the general improvement there has been perceptible diminution in the size of the bulbous finger-tips.

The other case—that of a woman aged 30—is of practical interest clinically and therapeutically. She had suffered from her symptoms, which are those of bronchiectasis, since the age of 12, when she had pneumonia and bronchitis after a wetting. She too had never been treated. On admission she presented the dusky aspect and the bulbous finger-ends distinctive of the affection. She was seven months pregnant. Her chest symptoms had become aggravated since the beginning of her pregnancy, and for six weeks she had been bed-ridden with severe paroxysms of cough, profuse foul expectoration, and orthopnoëa. In view of the severity of her chest symptoms and in spite of the complication of her advanced pregnancy, I decided in favour of the postural treatment as likely to afford the most speedy relief. In this I was not disappointed. Soon after the patient was induced to lie back, and the foot of the bed had been raised about

twelve inches, she began to experience marked relief from the harassing cough, and relative facility in bringing up the expectoration. The position was well borne for two or three days, but as it then gave rise to slight discomfort and dragging from the pelvis, the intermittent plan was adopted, and the bed raised only for periods of an hour two or three times a day. Ichthyol internally proved very beneficial in this case also. After a stay in Queen Charlotte's Hospital, where she was delivered, she returned to St. George's Hospital for further treatment, and was now able to get the additional advantage of respiratory exercises, which her previous condition did not permit. Under this systematic treatment she made considerable further progress in every way.

I have treated, with similar results, cases of chronic catarrh in adults and children, and I believed that where no contra-indications exist it will be found beneficial in a large number of bronchial affections, particularly when it can be associated with suitable respiratory exercises.

### III.—*The Diagnosis of Sciatica: A Demonstration of Two Practical Signs.*

In the less severe cases where the diagnosis from other painful affections, particularly those of the hip, may not be obvious, these two signs are easily applied and are distinctive.

(1) *Lasègue's sign*<sup>1</sup> is a well known test for sciatica which I may demonstrate on this subject in the absence of the patient who has now returned to his home relieved.

The case was a good illustration of the difficulty which sometimes arises in diagnosis. G. S., male, aged 38 (*Med. Reg.*, No. 886, 1901), with bad teeth and stumps, was admitted under the care of Mr. Grimsdale on account of recent paralysis of the right internal rectus which had occurred suddenly; but for one month previously he had suffered pain across the loin and pain had also gradually developed along the course of the right sciatic nerve before the eye was affected. On account of this pain, which was regarded as sciatica he had

<sup>1</sup> C. Lasègue: "Considérations sur la Sciatique." *Etudes Médicales*, T. ii., 1884.

spent one week in bed. Mr. Morley, my house physician, was impressed with the view that the case might be one of hemiplegia and the cause perhaps syphilis. To myself the case appeared to be rather one of subacute sciatica complicated with other nerve symptoms. Having recently become acquainted with the signs in question I applied them as a test with striking results, both the signs pointing to the existence of sciatica. During his stay in the hospital from May 8 to May 30 there was no rise in temperature ; he took iodide of potassium, sulphur, alkalies and salicylate, quinine, and hot air baths and he improved rapidly.

Lasègue's sign is as follows :—In the relatively mild cases in question a full length and perfectly symmetrical dorsal decubitus can be assumed, but if the patient be made to sit up the previously extended leg is found to become rigidly semiflexed at the knee ; it cannot be straightened by any voluntary effort and hardly yields to the most forcible attempts at extension, returning with a jerk to the previous angle as soon as the strong pressure is taken off. But it is spontaneously straightened if the patient lies down again. This is the first and most constant of the two signs. A modification of it may be obtained whilst the patient remains in the dorsal posture. In this position the unsound leg cannot be raised with unbent knee to a right angle with the trunk. As it is lifted from the bed the knee becomes gradually flexed—and if its flexion be forcibly opposed pain is set up. The flexion gives way when the limb is lowered, and the leg is then quite straight.

(2) *The crossed sciatic phenomenon of J. Fajersztajn.*—This interesting sign was exceedingly well marked in my patient. Fajersztajn, who has recently described it,<sup>1</sup> finds it present in the majority of cases of sciatica. In a series of forty-one cases of rheumatic sciatica it occurred in twenty-five and was doubtful in five. The patient being on his back the bad leg cannot be raised without bending the knee as stated ; but the sound leg can be raised to a right angle with the hip without any flexion at the knee. This, however, cannot be accomplished without pain and sometimes severe pain. The pain is not felt on the sound side, but in the sciatic nerve of the other side. The explanation is not very obvious.

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<sup>1</sup> *Wien. Klin. Woch.*, January 10, 1901.

Fajersztajn has made experiments upon the dead body to prove that stretching the sound nerve might interfere with the nerve affected. Perhaps the pain is due to a slight tilting of the pelvis incidental to raising the sound leg. At any rate the phenomenon is clinically of some importance as it may by its disappearance, as in the case which was under my observation, indicate a stage in the progress towards recovery.

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BY DR. THEODORE WILLIAMS.

*Tuesday, June 25, 1901.*

Dr. Theodore Williams showed two cases of secondary cavities in phthisis, exemplifying the spread of tuberculosis in the lung by re-inhalation of sputum. In the first case—that of Elizabeth H., aged 21—a left apical cavity had been followed by the formation of one at the left posterior base; and in the second—Henry R., aged 16—a cavity at the right apex had given rise to one in the dorso-axillary region, where the tubercular disease was still in progress. In both instances the tubercle bacilli were largely present in the expectoration. The formation of these cavities affected the prognosis of the cases very unfavourably.

As a contrast to these patients, Dr. Theodore Williams showed two cases of bronchiectasis. The first—James B., aged 49, a french polisher—had presented symptoms of chronic bronchitis for two and a half years, and gradually the cough had become more convulsive and the expectoration offensive, abundant, and, for the most part, purulent. It had been examined a number of times, but no tubercle bacilli had been discovered; only various kinds of streptococci and micrococci. The physical signs showed several extensive cavities in the upper left lobe, with considerable fibrosis and a certain amount of bronchial catarrh. There was dyspnoea on exertion, and the aspect of the patient was that of a man older than his years. He had been treated by Dr. Kidd, of the Brompton Hospital, by inhalation of crude creasote vapour, prepared by volatilising creasote in a small chamber, where the patient inhaled for fifteen minutes daily.

The result had been that the amount of sputum had diminished and the offensive odour had disappeared, and the cough was less troublesome. The patient seemed to have greatly improved.

The second case of bronchiectasis was that of a girl, aged 16, Isabella P., in whom the dilated bronchi were situated in the lower left lobe, where the disease was apparently of recent origin.

Dr. Williams drew attention to the points of difference between these two classes of cavities, bronchiectatic and tubercular, by which a correct diagnosis may be arrived at.

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BY DR. GUTHRIE RANKIN.

*Tuesday, July 2, 1901.*

CASE I.—*Mitral Disease.*

The history of this young woman makes clear enough the cause of the valvular disease from which she has so long suffered. She had chorea when a child, and twice since has had an attack of rheumatic fever. I need not trouble you with details as to her illnesses; she has had many, and all of them have been of the rheumatic type. I have seen her from time to time on account of the heart mischief which these illnesses have caused, and my principal reason for bringing her here to-day is that I am able to state, from personal observation, that she has gone through at different times every variety of murmur which is known to be associated with mitral disease. At the present moment you will all agree with me that the only bruit present is systolic in rhythm, but none the less I believe her case to be one in which such a systolic bruit is more indicative of stenosis than of incompetency of her mitral valve. It goes without saying that a systolic murmur can only be produced at the mitral orifice by a regurgitant stream, but regurgitation is not necessarily, nor always, associated with contraction of the orifice. Many of us are rather apt to hurriedly ascribe every systolic murmur heard in the mitral area to simple regurgitation and nothing else, and this case is of interest because the physical signs possess characters which clearly denote the

dependance of the murmur upon stenosis, and that in spite of an entire absence of the well-known harsh presystolic sound which is pathognomonic of that condition. The points to which I would specially call your attention are, first the character of the pulse; you will observe that it is small, shabby, and very markedly irregular. You will further notice that the woman is short of breath and that she is bothered with a troublesome cough; she looks, moreover, badly nourished and is none too well developed. Her growth might indeed be described as stunted. The shortness of breath on exertion or excitement, and the cough, together with occasional attacks of uncomfortable palpitation are the only subjective signs she now complains of. On palpation the apex-beat is diffuse but within the nipple line; there is a slight thrill running up to the first sound, and the right area of cardiac dulness extends to the right sternal edge. On auscultation a soft systolic murmur is heard over the situation of the apex, whence it can be traced up to the auricular area in the second left interspace. The murmur is not conveyed into the axilla but is replaced at a short distance outside the nipple line by an impure first sound. The character of the first sound is of importance, it is imperfect and partakes distinctly of the slapping quality which we have all read about; it is followed by a second pulmonic sound which is sometimes strongly accentuated, at others reduplicated. These characteristics are very different from what we expect to encounter in cases of simple regurgitation. At previous periods of this woman's history she has presented a true presystolic bruit, but the only evidence now present which is at all suggestive of such a murmur is the slight thrill which you can all feel and the thump which precedes the systolic murmur.

#### CASE II.—*Unilobular Cirrhosis of the Liver.*

This patient is a woman of 56 years of age, and when she first came under observation at Waterloo Road, about two years ago, she was hastily and erroneously labelled as suffering from enlargement of her liver, probably of a malignant type. The grounds for this diagnosis were a history of gall-colic lasting over some years, loss of weight, jaundice, and increasing debility. On examination her liver was found enlarged and rough, but not nodular, and she complained

of tenderness on manipulation. These facts, coupled with her age, made the theory of malignancy a not unlikely one. Her jaundice then was very slight, and under treatment it seemed to disappear, but after a time it returned, and has now been permanent for fully nine months. Her attacks of gall-colic have ceased, and though her own record of loss of weight before coming to the hospital may have been true, there has been no continuance, because to-day she is only three pounds lighter than she was two years ago. Her jaundice is gradually increasing, the evacuations are pale but not colourless, and the urine is loaded with bile. It is very doubtful whether she has much subjective pain, and the local tenderness at first observed has disappeared. Her liver is larger than when originally examined, and it still presents a rough but non-nodulated surface. She is subject to attacks of great mental depression, and she states that every now and again she experiences unpleasant sensations as though she did not know what she was about and was "going off her head." Her appetite is good, and she has never suffered from sickness. The urine, apart from the excess of bile, is normal, and there is neither anasarca nor ascites. With such a history I think we may conclude that we have here to deal with one of these comparatively rare cases of unilobular cirrhosis; though if her story is to be believed, there is no history of alcoholic excess to account for it. Captain Pinch has kindly put under the microscope a beautiful specimen of this variety of cirrhosis, and I would beg of you to look at it, because a single glance at his specimen will demonstrate the nature of the pathological change and explain why, in cases of this kind—as distinguished from those belonging to the multilobular type of the disease, where the fibroid changes take place in the tracts of connective tissue supporting the ramifications of the larger branches of the portal vein—the patient develops permanent jaundice, but escapes dropsy and the other phenomena which follow upon portal obstruction. It is still a moot point whether this fibrosis originates in and around the bile ducts or the smaller branches of the portal vein, but whichever is the starting point of the degenerative process, there soon ensues a large formation of new small bile ducts in the pathological fibrous tissue. In all cases of unilobular cirrhosis there is some liability to an accession of acute cerebral and other symptoms, which, when they arise, can scarcely

be differentiated from those associated with acute atrophy of the liver, and which speedily prove fatal.

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## LARYNGOLOGY AND RHINOLOGY.

BY DR. ST.CLAIR THOMSON.

*Friday, June 28, 1901.*

### *Anosmia.*

A case was brought forward for consultation by Dr. McLatchie. Anosmia, or loss of the sense of smell, is a symptom rather than a disease, but it is convenient to study together all the possible causes of this symptom, as treatment and prognosis are both based on a determination of the aetiological factors.

The sense of smell depends on odorous particles reaching the upper and middle meatus of the nose, where they come in contact with the terminations of the olfactory nerve. The use of this sense, therefore, entails a healthy condition of the air passages, allowing the approach of the odorous particles, as well as a sound condition of the nerves, the tract to the brain, and the centres.

It will be seen that interference with the sense of olfaction may be of (*a*) a respiratory or (*b*) an essential character. Hence anosmia may depend on interference with (*a*) the vestibule of the nose, (*b*) the free passage of air through the nose, (*c*) the olfactory mucous membrane and nerve-endings, or (*d*) the olfactory nerves and their centres. As one side of the nose is quite sufficient for the perception of odours, it is seldom that anosmia is complained of unless the affection is bilateral.

The patient's own statement—as in the case under examination—can generally be taken with regard to the loss of the sense of smell, but it can be more carefully tested by the use of otto of roses, musk, valerian, or assafoetida. Care is of course taken to avoid the use of ammonia, vinegar, and other pungent vapours, which are perceived by the branches of the third nerve, and not by the olfactory.

Dr. St. Clair Thomson then examined the patient to see whether one or more of the following causative conditions were present :—

(a) RESPIRATORY.—(1) Modification or destruction of the alænarium, which would allow the air to be drawn along the floor of the nose, instead of being sniffed up into the olfactory region.

(2) Alar collapse. Facial paralysis. Obstruction by rhinitis, acute or chronic. Polypus. Deviation. New growths. Foreign bodies. Suppuration. Obstruction at, or stenosis of, the chonæ. Adhesion of the soft palate to the pharynx.

(3) Injury to the respiratory mucous membrane, caused by nasal lotions, especially those containing carbolic acid, or zinc, alum, or other astringents. The habit of sniffing up the nose cold water, cocaine, or snuff. Rhinitis. Atrophic rhinitis. Ozœna.

(b) ESSENTIAL.—(4) The diagnosis of essential anosmia is frequently only arrived at by a process of exclusion, after eliminating the possibility of all the previous causes. It may be due to congenital absence of the olfactory bulbs and nerves. It is not at all uncommon as a neuritis after influenza, and has been traced to lead poisoning and malaria. Amongst other essential causes are: fractures of the base of the skull, compression of the bulbs by meningeal lesions, and senile atrophy. General paralysis of the insane and locomotor ataxy, in their early stages, may affect the olfactory bulbs. Compression of the cortical centres may take place from abscess, haemorrhage, and tumours. The latter may also compress the fibres joining the centres to the bulb.

In some cases anosmia is due to hysteria, when it is often associated with local anaesthesia, which can be detected with the nasal probe. It may be inhibitory, having been originated reflexly by some intranasal or other operation.

None of the respiratory causes of anosmia were discoverable in the case brought forward by Dr. McLatchie, but in order to positively exclude every possible source of intranasal obstruction, it was advised that the nose, later on, should be painted out with a 10 per cent. solution of cocaine, so as to shrink the erectile tissue, and secure a more complete inspection of the recesses of the various meatuses.

As no central lesion was evident, the case was diagnosed as one of essential anosmia, due to a peripheral neuritis, the result of

influenza, which attacked the patient some six months ago, just before he became cognisant of his anosmia.

This determination of the cause of anosmia is most important from the point of view of prognosis. The prognosis is good if the anosmia is dependent on the first two classes of causes. The sense of smell has been restored even after a loss of forty years, when dependent only on nasal obstruction. In the third class of cases it is doubtful; and in the fourth class of cases it is almost hopeless—except when due to hysteria.

In the two last groups the outlook will depend on the duration, continuity, and intensity of the anosmia. It is always more promising if there has been any intermittence, but if complete and continuous for some months—as in the case under observation—there is little hope of success with the last two groups. The prognosis is worse the fewer the lesions there are to explain it.

The treatment in class 1 and class 2 will be directed to treatment of alar defects, nasal obstructions, and the avoidance of nasal lotions.

In the essential form (Group “*b*”) the hysterical form is treated chiefly by suggestion. In the other forms, if well established, there is little to be done; and hence, in the present case, the outlook was not hopeful. Electricity is of difficult application and doubtful value. Strychnine or quinine may be tried. Although it is not easy to see how it acts, the following has been recommended as a snuff by Lermoyez, to be used twice a day:—

R <small>y</small>	Strychnini sulph.	...	0·10
	Pulv. iridis	...	0·50
	Saech. lactis pulv.	...	10·00

\* \* \*

Cases of superficial glossitis and chronic otorrhœa were brought forward for consultation, and Dr. St. Clair Thomson exhibited two cases of epistaxis (from abrasion of the septum) and cases of malignant nasal polypus, tubercular gland of the neck, aural polypus, and tuberculosis of the pharynx.

CASES WITH COMMENTS FROM THE SURGICAL CLINIC.

BY MR. HUTCHINSON.

*Pityriasis Rosea of the Psoriasis type.*

(Dr. Sequeira's case.)

The patient, Marie Cole, a well-grown girl of 11 was covered with an eruption which might have been taken for psoriasis. The patches were furfuraceous and somewhat congested. The whole duration of the eruption was stated to have been only about three weeks and the first patch, "the herald patch," "Brocq's patch," "the mother patch," had been present behind the left knee for a week before the general eruption appeared. Dr. Sequeira who brought the patient had already given the diagnosis of "Pityriasis rosea," which I confirmed, remarking that it was a remarkably extensive eruption and approached more nearly the type of psoriasis than usual. As is invariably the case there was no history of other members of the family being affected. I drew attention to this very remarkable clinical fact, remarkable because the disease would appear to spread very rapidly by contagion over the surface of the patient's body and to be quite independent of constitutional predisposition. Yet the cases are always isolated ones.

*Thursday, May 16.*

*Sacculated Abdominal Aneurism.*

(Dr. Brunton's case.)

An engine stoker, who had travelled much and been accustomed to lift weights, &c., was the subject of this case. There was a rounded pulsating tumour, as big as the very largest orange, immediately beneath the umbilicus. Its pulsations were detected by the slightest touch, and were distinctly expansile. It bulged perhaps more to the left than to the right, but was nearly in the middle line.

The patient was tall and thin, and the examination was easy. The history was that there had been pain in the region of the tumour for about a month and that it had often been attended with a sense of faintness, obliging him to desist from work and sit down. The tumour itself had only been discovered a week ago. On enquiry as to the history of any extra strain, the man told us that about six months ago he had, after lifting, experienced a sudden pain, which shot down into his thigh. It passed away, however, and he took no further notice of it until pain recurred about three or four months later. There was no history of syphilitic disease. Having adverted to the deceptive conditions often presented by the excessive pulsation of the abdominal aorta, I said that I thought it was impossible to be deceived in the present instance, and that there was no doubt that the man had a sacculated aneurism. The treatment suggested was that the man should be made to keep his bed, preserving the recumbent position with the utmost strictness, that he should eat lean meat and abstain from all fluids as much as possible, and lastly, that he should take large doses of iodide of potassium.

#### *Miscellaneous Cases.*

Amongst other cases were one of rheumatoid arthritis, one of lupus vulgaris showing the "apple-jelly" deposit in great perfection (Dr. Macnamara), and one of scratched eczematous abrasions on the leg in a girl who presented a good example of thick-lipped struma with eczematous ulceration of the nostrils (Dr. Carr). The leg had been sore for twelve months, and some discussion ensued as to whether it was an example of factitious disease, a view which I could not accept.

*Thursday. June 6.*

#### *Very Large Cartilaginous Tumours of the Digits of One Hand in Association with Defective Formation of the Elbow-joint.*

Amongst the cases which presented themselves on Thursday, June 6, was a very remarkable one in which cartilaginous tumours of the digits were associated with the defective formation of the elbow-joint. The patient was a lad of 16. His right upper limb alone was affected. The digits of this hand were crippled and

distorted by numerous and large cartilaginous bosses which grew irregularly from the phalanges and in some instances from the metacarpal bones. At first sight it might have been thought that his hand was quite incapacitated, but this did not appear to be the case and he showed us that he could still grasp objects with it and assured us that it was useful.

On careful examination I advised that his little and index fingers should be removed. He had previously been urged to have the hand amputated, but had, I think wisely, declined this measure. As an instance of non-symmetrical development of multiple cartilaginous tumours his case presented a feature of great interest. And this was much heightened by the condition which we found at the elbow-joint. Here the end of the radius was quite disengaged from the humerus and projected under the skin. The finger could easily be placed in what should have been the concavity of its extremity, but which was filled up and rounded. This congenital displacement appeared to be due to want of development of the outer condyle. The movements of the joint, both flexion and pronation, were quite free, and the olecranon and inner condyle appeared to be normally developed.

*Erythematous Urticaria due to Sweating, &c., and persisting during Long Periods of several successive Years.*

Mr. Hitchins brought before us a very interesting example of urticarious erythema of the trunk and limbs. The subject was a man of about 50, in good health, who told us that for many years he had suffered from attacks which, with exacerbations, usually lasted over several months. He was worse in summer weather, but his liability had sometimes commenced as early as March. It was an eruption which varied much from day to day, and often fading in the course of a few hours, but never, during the periods of liability, leaving the skin quite free. When the man was before us it was not at its height. His arms, thighs, and abdomen were, however, very red, and showed many clusters of low wheals quite definitely of urticarious type. On the chest the skin was pale, but streaks of congestion were easily produced by scratching. There were also many crescentic lines of dilated capillaries, which marked where the

wheals had been. Fully agreeing with Mr. Hitchins that the nominal diagnosis must be "urticaria," we proceeded to discuss the peculiar features of the case, and more especially the question of causation. There appeared to be no reason whatever to associate the eruption with errors in diet; the man told us distinctly that he had never thought that any article of food brought it out, or made it worse. That it had to do with clothing he was convinced, and he had long ago forsworn all woollen under-garments, and was now wearing only cotton. He had been obliged, he said, to leave off his wool vest many years also, because it irritated his skin. He did not, however, remember that he had been specially susceptible when a boy.

In illustration of this case we had brought up from the Museum the portraits of two or three more or less similar ones. The original of one of these was a postman who, year after year, in summer, used to come to the Blackfriars Hospital for an eruption on the vest-covered parts of his trunk. It was in part urticarious and in part a lichen marginatum and was at the same time persistent and variable. I remarked that we must in these cases take into consideration several distinct elements of causation. In the back-ground there was peculiarity of skin—either congenital, or induced, or both,—which rendered it specially susceptible to irritation and prone to develope wheals. Next we have the effect of clothing, but it would be a mistake to attach too much importance to it. Everything which induces flow of blood to the skin and tends to excite its glandular apparatus would assist. Thus if the sudoriferous glands were made to act freely the fluid issuing out might act as an additional irritant. If the sebaceous glands and the hair follicles became congested we should have the lichenoid papules, which are a frequent concomitant. Such eruptions might be named if we are zealous to denote causes in our nomenclature "vest eruptions," or "summer eruptions," or "sweat eruptions," but none of these terms would suffice to recognise their totality. Hot weather, woollen underclothing, profuse sweating all take their share and behind them all we have to take into account the cutaneous idiosyncrasy of the patient. In devising measures of treatment all these elements of causation must be carefully kept in mind.

*Multiple Lupus Vulgaris following Strumous Disease of one Elbow-joint.*

A case of much interest in reference to the possibilities of infective spreading in tuberculosis came under our notice in July. The patient was a young man who had large patches of lupus vulgaris on the backs of both hands and also on some other parts. These patches presented the ordinary characters of a central scar and crusted borders. He had also a large scar covering the left elbow region, and this joint was partially stiff. The external epicondyle had apparently been removed. The history given was that disease of the elbow-joint had preceded the lupus by some years and that an operation had been performed. Probably the operation was an erosion of the joint, and the result was quite satisfactory for there was very fair motion and the parts had been for some years soundly healed. It was not till some years after the beginning of the joint disease, and so far as the patient could remember about the time of the operation, that the lupus patches appeared. Several of the latter appeared almost simultaneously and they had persisted ever since. It is not very often that we can trace lupus vulgaris to any probable infection from tubercular disease of other parts. More usually it stands alone. Now and then, however, joint or bone or gland disease is found to have preceded it, and of this we appear to have an example in this case.

*Case illustrating the fact that Rhagades are not always due to Syphilis.*

(Mr. Hitchins' patient.)

This patient was brought by Mr. Hitchins in order that an opinion might be expressed as to whether a condition of ulcerating dermatitis between the toes could be believed to be other than syphilitic. There was no history of syphilis and the patient was a married man with healthy children. All his toes of both feet were involved and in their clefts were sores caused by peeling of the epidermis and attended by much fetor. The conditions were in all very similar but varied in degree. In one only a sodden white condition of swollen epidermis, as yet without peeling, was present. I directed especial attention to this one as illustrating the early stage and commented upon the fact that all were much alike and

that in none had the inflammation extended to the nail bed or involved other parts of the skin. The inference from these facts was, I suggested, that the conditions were consequent upon pruritus, friction and irritating secretions, and had no connection with syphilitic taint. The man admitted that his toes had itched intolerably and that he had rubbed them freely.

In commenting on this case I remarked that it was, perhaps, far too frequently taken for granted that the condition known as rhagades was always syphilitic. In similar way it used to be assumed that "psoriasis palmaris" was always syphilitic. As a matter of fact neither the one nor the other of these affections was by any means necessarily connected with specific taint. In many instances in which there was a remote history of specific disease still the connection of the one with the other was indirect and often doubtful. Nor do the results of treatment help us much, for undoubtedly mercury, both internally and topically, is a very valuable remedy in both. It is not difficult to explain the formation of sores between the toes without having recourse to the syphilitic hypothesis. The parts are liberally supplied with glands which, when irritated, secrete a very offensive fluid. Next the coverings of the feet press the toes together and thus prevent the escape of secretions and maintain perpetual contact. If pruritus once begins it is intolerable and if the patient once begins to rub he will go on. The skin in the bottom of the cleft is, however, thin and it does not bear rubbing but soon becomes excoriated. Thus under these combined influences rhagades are produced and they are often very difficult to cure. As to treatment, in the first place the patient must abstain from rubbing; not unfrequently, however, the clefts have become so sore before the surgeon is consulted that there is no need to insist on this. Next the utmost cleanliness must be observed and broad-toed boots must be worn which do not press the toes into contact and which leave room for lint to be placed between them. As to local applications my favourite one is a solution composed of equal parts of solution of diacetate of lead, the liquor carbonis detergens and spirit of wine. This, undiluted, should be applied between the toes and allowed to dry. It is almost infallible for the object of abating pruritus. Then dry lint covered with a mercurial

ointment, say half a drachm of calomel to an ounce of vaseline, should be applied. These dressings should be made night and morning and on each occasion the feet should be well washed in warm water. In some cases, but only in a small minority, a tendency to gout may aggravate the itching, and if that is the case it must be attended to.

*Severe Inherited Syphilis wholly without Parental History.*

(Dr. Sequeira's case.)

The infant, in this instance, was 4 months old, and although not cachetic, presented the most characteristic conditions. Its buttocks, thighs, scalp, &c., were covered with macular patches of coppery tint, and those around the anus had coalesced and approached the condition of condylomata. There was pronounced snuffles, and the skin of the cheeks and neck was of a dusky-brown tint. The eruption had been first observed about a month after birth and had been increasing ever since, yet the infant had remained in good health. It was nursed at the breast, and the mother's nipples had not been infected. No one who saw this infant entertained the slightest doubt as to the diagnosis. We were met, however, with an absolute negative as regards parental history. The mother, who brought it appeared to be quite free from symptoms, and alleged that she had always had excellent health. She made the same statement as regards her husband. They had been married fourteen years, and their eldest child was 13; a second child was 3 years old, and subsequent to the birth of this last, there had been miscarriages. Between the first and the second the husband had lived most of the time abroad, but since the second he had not left home. We carefully enquired as to any primary sore contracted by the infant at the time or subsequent to birth, but could obtain no history; indeed, the early appearance of the eruption (one month) negatived such a suspicion.

I remarked, in commenting on the case, that there could be little or no doubt that the father of the infant had suffered from primary syphilis within two year's of the date of conception. There appeared no reason to suspect the mother, and we had an interesting proof (in addition to thousands of others) that a woman might carry a severely-tainted child without herself exhibiting any symptoms of

ill-health either during her pregnancy or afterwards. Further, in the fact that the infant had not infected its mother's nipples, we had an illustration of Colles' law and a suggestion that the mother, although never ostensibly affected, had really in some way acquired immunity. No opportunity had been afforded us for examining the woman's husband, and we had only her assurance that he had not been ill. That he had not infected his wife seemed almost certain. On the supposition that he was the father of the child, the belief that he must have acquired syphilis recently, was supported by the fact that the former children of the marriage were healthy. It was, however, impossible to shut our eyes to the suggestion that this child might possibly not be really his.

*Severe Inherited Syphilis without Parental History.—Multiple Epiphysitis.*

(Dr. Ewan's case.)

Amongst the cases brought to us on July 18 was a syphilitic infant, in whom the family history was almost the exact counterpart of that given above. The mother came with the child, and alleged that, so far as she knew, neither she nor her husband had ever ailed anything. They had been married eight years, and had three elder children, all in good health, and none of whom had presented any infantile symptoms. The eldest of these, a girl of 7, attended, and was a specimen of good health and growth. Yet there could be no doubt that the infant was suffering severely from inherited syphilis. It was only five weeks old, and was stated to have begun to snuffle, &c., at three weeks. It was the subject of epiphysitis of the bones of both elbows and both ankles and in slighter degree of those of the knees. All these joints were considerably swollen and very tender. The infant's facies was characteristic, the skin being of a dull lean-of-ham tint, the bridge of nose depressed, and the nostrils clogged. There was no visible skin eruption. On both sides there was a small hydrocele, and the left testis was possibly enlarged. I pointed out that the early development of symptoms (third week) entirely shut out the supposition of disease acquired at birth, whilst their severity strongly supported the belief that the parent from whom the disease was derived had had the primary disease at no very distant date.

COMMITTEE OF INVESTIGATION ON  
CLIMATOLOGY.

DISEASE IN NORTH-WEST AUSTRALIA.

THE following items of information respecting the Kimberley District of Northern Australia, were supplied to a Member of our Committee on Climate. Our informant was Mr. A. Freeman, a very intelligent man, who as Superintendent of Mounted Police, had resided for ten years in different parts of the district. It is a part which has only during the last twenty years been, in any sense, taken possession of by white men, and even now it is occupied only by a few ranchers who feed herds of cattle on the plains. Thousands of kangaroo, of various species, still share these plains, and there are emus, bustards, and wild duck in abundance. The climate is tropical; the district being only from 15° to 18° south of the Equator. Mosquitoes and other insects abound, and malarial fevers occur. The business of the police is to protect the ranchers from the blacks, and for this purpose mounted detachments provided with tents move about the country. Mr. Freeman had himself suffered from malarial fever and had on one occasion nearly died of typhoid and on another from scurvy. He admitted that his scurvy had occurred under exceptional conditions of privation, but still asserted that the supply of fresh vegetables was very precarious, and that they were often reduced to eating "scurvy grass," which he did not like. Only at the farm houses could fruit, milk, and fresh vegetables be had, and these farms were at great distances from each other.

Asked whether the natives were really a source of trouble, the reply was:—"Yes, the natives near the coast are a far finer race of men than those in the interior. They are better fed, better grown, and far more aggressive, they are a serious danger to the farmers. No sheep are kept in the district, partly for fear of them, and partly on account of the wild dogs or dingoes."

"What do the natives feed on?"

"Anything they can get, game and fish chiefly, but nothing comes amiss. They are still cannibals, and are credited with eating their own babies and any of their own people who may chance to be killed."

"Do they eat salted or dried fish?"

"I do not think that they are provident enough to cure fish, but they are expert fishermen and get a great deal of it on the coast."

"Have you seen leprosy amongst them?"

"I think I have, at any rate I have seen some who had lost their fingers and who, I supposed, were lepers. Syphilis is very common and produces great disfigurement."

"Do the colonists use salted or dried fish?"

"No."

"Do the cattle suffer from any plagues?"

"There have lately been heavy losses from what they call 'red water.' It is caused by a kind of tick which sucks itself full of blood and then falls off. After it has been bitten, the ox sickens, passes water as red as blood, and often dies. After having once suffered, the ox is immune and may be attacked by the tick again without any material injury. This immunity seems in time to be acquired by the whole herd and to be transmitted to offspring."

"What market have the farmers of the Kimberley territory?"

"They send their cattle, &c., to their port, Wyndham, whence they are shipped to Perth."

#### DISEASE IN MADAGASCAR.

A WELL-INFORMED missionary who had lived ten years in Madagascar, chiefly in the capital, Antananarivo, told us that syphilis was the disease which was the curse of the country. He described it as being terribly prevalent and severe. Of leprosy he had seen a good deal, but did not think that it was increasing. He had never known a European to suffer from it. The natives eat much rice, and are very fond of dried fish. A small fish which abounds in the rivers is very extensively caught, sun-dried, and eaten with rice. He assured us that the new rice is not the absolutely tasteless article which those who know it only in the dried state might suppose it to be; but he admitted that it was an article of food with which some

condiment, such as preserved fish, is always acceptable. The Europeans in Madagascar do not eat the dried fish. Salt is expensive, and is, he believed, chiefly imported from Marseilles. Although Antananarivo is inland and in a sort of highland situation, malarial fevers may originate in it. He considered that the French occupancy was working well for the country and the natives, if not for France. There were very few French immigrants other than officials ; fifteen officials to one colonist was the calculation. Large districts, especially in the south, are still unsubdued, and likely to be so for a long time ; but the spirit of the Hovas inhabiting the regions near the capital is quite broken, and they are not likely to give trouble. Missionaries skilled in medicine are much needed.

#### SHARK-EATING IN PEMBA.

A MISSIONARY lady from Pemba (north of Zanzibar), where there is much leprosy, tells us that the natives are much addicted to eating dried shark. She considers it a very unwholesome fish, quite apart from any hypothetical risk of leprosy, and says that she always did her best to dissuade her patients from eating it, and could in many instances tell at once when her prohibition had been disregarded. It was from the same lady (Miss Emily Hutchinson) that we received the specimens of the chigoe mentioned at page 53.

#### BOOKS RECEIVED FOR THE LIBRARY AND REVIEW.

“Text-book of Medicine” (2 vols.), by G. A. Gibson, M.D. Presented by the Author.

“Essays on Consumption,” by J. E. Squire, M.D. Presented by the Author.

“The Extra Pharmacopœia,” by Martindale and Westcott. Presented by H. K. Lewis & Co.

“Transactions of Dermatological Society of Great Britain and Ireland.” Presented by the Society.

“Transactions of College of Physicians of Philadelphia.” Presented by the College of Physicians of Philadelphia.

"Diseases of the Thyroid Gland," by J. Berry, F.R.C.S.  
Presented by the Author (see page 91).

"Index of Symptoms," by R. W. Leftwich. Presented by  
Smith, Elder & Co.

"Studies in Human and Comparative Pathology," by Woods  
Hutchinson, M.D. Presented by Glaisher & Co.

"The Asphyxial Factor in Anæsthesia," by H. Bellamy Gardner.  
Presented by Baillière, Tindall & Cox (see page 91).

"Text-book of Pathology," by Stengel. Presented by W. B.  
Saunders & Co.

"Pathology and Surgical Treatment of Tumours," by Senn.  
Presented by W. B. Saunders & Co.

"Clinical Examination of the Urine," by Ogden. Presented by  
W. B. Saunders & Co.

"Text-book of Histology," by Bohm, Davidoff & Huler. Pre-  
sented by W. B. Saunders & Co.

"Text-book of Embryology," by J. C. Heisler. Presented by  
W. B. Saunders & Co.

"Report of Plague in Sydney," by W. Ashburton Thompson.  
Presented by the Author.

"Laryngeal Tuberculosis," by Richard Lake. Presented by the  
Author.

"Diseases of the Nose and Throat," by F. de Havilland Hall  
and H. Tilley. Presented by the Authors.

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#### REVIEWS AND NOTICES OF BOOKS.

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#### MAP OF AFRICA

(Continued from page 44.)

Zululand is that part of Natal (recently annexed) which is north  
of the Tugela river.

Still further north than Zululand, and like it with the sea in the  
east and the Transvaal on the west, is Tongaland. It touches  
Portuguese territory—Mozambique, on the north. In these districts

(Zululand and Tongaland) leprosy has as yet probably been unknown.

South of Natal and on the coast is the district marked on the old maps and some of the newest as Caffraria. The northernmost part of this is now known as Pondoland. Here is some of the most beautiful and productive country in South Africa.

Some maps omit altogether the mention of Griqualand East, and very few of the geographical writers make any detailed mention of it. It is however a district of the utmost importance as regards the leprosy question, and will have to be frequently mentioned in the discussion of it. A migration of "bastards" (Dutch-Hottentots) took place from Griqualand West across Basutoland and it is reputed that they carried leprosy with them. This district is the north-western portion of Caffraria, south of Natal, west of Pondoland, and on the eastern slope of the southern part of the mountain range of the Drakensberg.

Basutoland is a district of the utmost interest for the medical geographer. It is of small area, but well placed in a mountainous region just west of the main ridges of the Drakensberg, north of a branch of the Orange River, west of Natal and Caffraria, and between these and the Orange River Colony. The Basutos who inhabit it are a warlike race of Kaffirs, but now well under British rule. To a small extent they suffer from leprosy and not a little from syphilis in its framboesial type.

If what has been known as the *Orange Free State* should be henceforth designated the *Orange River Colony* the new name will be very appropriate. The district is enclosed, watered, and drained by tributaries of that river;—the Vaal, which is its northern boundary, being of course the chief.

The enormous territory named Bechuanaland and "Bechuanaland Protectorate" occupies the middle part of South Africa from the north bank of the main stream of the Orange River as far north as the Zambesi and Chobe. It is sparingly populated by tribes of Bantu race, and much of it is desert. Part of the so-called Kalahari desert is included in it. The German territory limits it on the west, and on the east is the Transvaal. Griqualand West, which now has no Griquas and in which are the Kimberley diamond mines, is to the south of Bechuanaland. With the larger part of the latter the

English colonist need not for some years to come much concern himself. It has, however, been considered to be the key to Central South Africa.

As a health resort, we may hope that much of this district will prove of great value. We must wait, however, until the arts of civilisation have advanced into it. Much of it is from four to five thousand feet above sea level, and, whilst there is a good water supply, the climate is dry and warm. The nights are cold and may be considered bracing. The dryness of the atmosphere counteracts the effect of the midday heat, and the early mornings are said to be delightful. The Bechuanas are a mild and peaceable race of the Kaffir stock.

The territory for which the genius and enterprise of Mr. Rhodes secured the benefits of British civilisation, and which is now known as Rhodesia, is of enormous extent. Not only was its annexation a gain for the native races, but a most valuable acquisition for England, Europe, and the world. It is for the most part healthy and productive, and capable of supporting in peace and prosperity a very large population of both white and coloured races.

Had it not already received its appropriate name, it might have been called the "Zambesi Colony." The great Zambesi River flows through it and divides it into a northern and southern territory, or trans- and cis-fluvian. Of these, the northern is by far the larger, but it is as yet not populated by white men. It is with the southern, which contains Salisbury and Bulawayo, that we have for the present almost solely to do. It is not necessary to write that a country which is only  $15^{\circ}$  below the equator, and has a large river running through it, must have some districts which are not favourable to the health of Europeans. Such is the fact. In districts near to the river there is plenty of malaria, and the tetze fly makes the maintenance of cattle impossible. The districts, however, in which Salisbury and Bulawayo are situated and to which, as yet, European colonisation is chiefly invited are, however, magnificently situated on a lofty plateau and present conditions in every way favourable to health. Southern Rhodesia is divided into two large areas under the names of Mashonaland and Matabeleland, Salisbury being the capital of the one and Bulawayo of the other. Both the towns are in districts from four to five hundred feet above the level of the sea. A recent

writer and a late resident at Salisbury, Mr. H. Marshall Hole, M.A., says of them :—

"At this elevation the air is cool and pleasant almost throughout the year. Nothing approaching the heat of India is known to us, while in our bitterest weather the thermometer rarely falls below freezing-point. In certain districts the granite basins below the soil retain the surface moisture and form swamps. Here the decaying vegetation is apt to engender malaria towards the latter part of the rainy season. Malarial fever is also found wherever the virgin soil has been first ploughed. It is, however, of a mild type and does not appear to leave permanent after effects, moreover it may be avoided by care. Towards the end of the rains the greatest precautions should be taken to avoid chills or exposure. . . . . Severe cases of fever, and particularly the "blackwater" type, only appear in those whose constitutions have been worn out by hardships or exposure, or who have resided, even for a short period, in the unhealthy regions which lie between Rhodesia and the east coast or in the immediate neighbourhood of swamps."

THE ASPHYXIAL FACTOR IN ANÆSTHESIA. By H. Bellamy Gardner.  
Pp. 63, price 3s. 8d. Baillière & Co.

There is little that is new in this little brochure but it is evidently the work of a practical and observant man. Its chief theme is the importance during the administration of an anaesthetic of looking out for the first indications of loss of oxygen by the blood. Now although the dangers of asphyxia have long been well recognised, yet their importance cannot be too strongly enforced. "Anoxæmia" is our author's favourite term. Although the scope of the principal chapter is implied in the title this special topic does not occupy more than half the book. We are offered two other valuable essays on points connected with the practical administration of anaesthetics. One of these deals especially with the value of admixture of oxygen.

DISEASES OF THE THYROID GLAND AND THEIR SURGICAL TREATMENT. By James Berry, B.Sc.Lond., F.R.C.S. Pp. 366. Price 14s. J. and A. Churchill.

This is a work which the friends of the author have long looked for with expectant interest. In 1886 Mr. Berry gained the Jacksonian prize for an essay on Diseases of the Thyroid, and in 1891 he delivered the Hunterian Lectures at the College of Surgeons, taking the same diseases as his subject. However much those who heard the lectures may have regretted the delay in their publication,

they have now full satisfaction in receiving a volume enhanced in value by the author's large experience in operative practice during the ten years which have elapsed. It is one which will doubtless be the standard authority on the subject of which it treats for many years to come. Its author is an accomplished observer, and he records his results with scrupulous care as to the accuracy of his statements. There is only one method of criticism by which such a work can be properly reviewed, and that is by analysis of its contents. We shall therefore pass *seriatim* through its principal chapters.

Chapters I. and II. deal respectively with anatomy and congenital affections, and call for but little comment. The pyramid or middle lobe, as distinct from the isthmus, is carefully described, and an attempt is made to establish a distinction between "accessory thyroids" and "parathyroids." Congenital defects both of hypertrophy and atrophy—the latter even to the extent of complete absence—may, we are told, occur both in man and the lower animals.

Chapter III. treats of atrophy, myxoedema, and cretinism; also of the relations of the thyroid to the sexual function. A certain degree of atrophy is usually coincident with advancing years, and leads to no ill consequences. All other forms of atrophy tend to the well-known cachetic phenomena. There is no real difference between sporadic and endemic cretinism, and the fatty tumours which are supposed to attend the former are to some extent mythical. It is admitted that various conditions of the sexual system—puberty, pregnancy, sexual excitement—may each be attended by temporary increase of the thyroid. A tendency to fatten is very rarely met with where the thyroid is diseased.

Chapter IV. proceeds to define the term Goitre and to describe its various forms—parenchymatous, cystic, fibrous, adenomatous, malignant, exophthalmic, &c.

Chapter V. is one of great interest and deals with endemic goitre, a subject upon which Mr. Berry is well known to have expended much labour. He discusses in excellent detail the supposed causes of endemicity and, excluding altogether the influence of climate, of configuration of soil, and of want of air and sunshine, arrives with tolerable confidence at the conclusion that some element received into the body in drinking water is the one and only cause. This is,

of course, the creed which has long been held, but it is very satisfactory to find that the critical investigation to which our author has submitted the facts gives it support. What the precise element in the water is cannot yet be stated. Certain facts point to the conclusion that it is animate rather than chemical, for water can, it is believed, be rendered innocuous by boiling and straining. It seems probable, however, that it is in some way associated with certain geological strata, and the value on the part of the medical observer of a sound knowledge of geology is well exemplified by the discussion through which Mr. Berry leads us.

Chapter VI. deals with symptoms and diagnosis and Chapter VII. with the special symptoms of dyspnoea from pressure. Chapter VIII. treats of inflammation such as we now and then meet with it in connection with fever, rheumatism and pyæmia, whilst Chapter IX. tells us that tuberculosis and syphilitic affections of the thyroid are both very rare but may occasionally be encountered.

Chapter X. deals with cystic formations and the transitional forms of ædenomata, and the relations of intracystic growths to malignancy. Omitting Chapter XI. as concerned with the exceedingly rare occurrence of hydatids, we come to the very important topic of exophthalmic goitre. This chapter is a long one. Mr. Berry's conclusion is that operative treatment is here useless, or even worse, and he speaks hopefully, though not so much so as he might perhaps have quite properly done, as to the prospects of recovery under other measures or from lapse of time.

Chapter XIII. treats of malignant disease and need not detain us. We may, however, note, in passing, that Mr. Berry entirely omits to mention the very interesting facts which concern the production of tumours in distant bones by infection from bronchoceles. The well known case recorded by Mr. Henry Morris stands as a good example, and another was not long ago before us in the Polyclinic Consultation Room and is recorded at pages 198 and 270. Others have been mentioned both at home and abroad and the facts are of great interest.

The remaining Chapters, XIV. to XXII., concern almost exclusively operative treatment and may be taken together.

The most important recent modification of practice has resulted from the observation that many tumours of the thyroid are

adenomata and not hypertrophies. These adenomata are isolated and encapsulated and may be shelled out, like their congeners in the mammary gland. Thus a mode of operating wholly different from extirpation of the gland or of part of it is appropriate to them. It is a question of diagnosis. Chapter XIX. deals with this recognition of cases suitable for enucleation. If the diagnosis be correctly accomplished the resulting operation is a comparatively simple one. No vessels are to be tied and no dissection made, but the tumour is to be exposed and turned out of its bed. Operations for the resection of parts of the gland itself are a very different matter, and attended by very different risks.

After stating that the subjects of goitre but seldom seek advice for any other inconvenience than that of dyspncea, the author proceeds to classify its most usual causes. Lateral compression producing the scabbard-shaped tube is admitted to be by far the most common. The influence of the isthmus in causing backward pressure is denied, and it is pointed out that it is only when the gland is low down and behind the sternum that injurious backward pressure can result. Irritation of the recurrent laryngeal nerves with dangerous or even fatal spasm of the glottis is admitted as an occasional occurrence, but with some reluctance to allow that it is frequent. A remark of much importance to the physician to the effect that in all cases of unexplained dyspncea the neck should be carefully examined, is enforced by some instructive cases in which the existence of a bronchocele had been overlooked. It is not the largest bronchoceles which are the most prone to compress the trachea.

Under the head, "Primary Chronic Inflammation," Mr. Berry gives us the narratives of a group of cases in which the general characters of the bronchocele implied malignancy, but the microscope failed to discover either sarcomatous or cancerous structure. It was to one of these cases that Tailhefer applied the term "*Inflammation chronique primitive癌éiforme*," and to another of which Mr. Bowlby gave the designation "*Infiltrating fibroma (? sarcoma)*." To those of us who hold that there is no natural boundary line between chronic inflammation and malignant growth these cases are very acceptable, and we scarcely participate in our author's zeal to claim as merely inflammatory, tumours the boundaries of which were

"quite undefined and which infiltrated the surrounding parts and did not push them aside" (page 140). At another page, Mr. Berry, himself, allows that "Even those who have had large experience in the microscopic examination of thyroid tumours will admit that it is often difficult to say where adenoma ends and carcinoma begins." To this may be added that in some cases in which distant infection has occurred the bronchocele had apparently been, for a time at least, of the ordinary parenchymatous form. We allude to the Henry Morris group of cases.

Of simple tapping of cysts Mr. Berry writes: "In many cases the cure may be permanent," but he qualifies this by adding, that in others intracystic haemorrhage may occur and the patient be placed in a worse condition. His conclusion is, that "Tapping of a goitre of any kind is a proceeding which should rarely, if ever, be adopted."

Although minute directions are given for the treatment both of parenchymatous and cystic goitres by injections (iodine, &c.), they are quoted from other authors, and Mr. Berry would appear to regard them with but little favour. Still less does he applaud the seton; and as to ligature of arteries he thinks that some of the cases so treated would have better been left to medicinal measures, and that others would have obtained more benefit with as little risk from extirpation of one-half of the gland. Under the cryptic name of *Exothyropexy* we have described an operation which consists in "cutting down upon the thyroid gland, dislocating it through the wound and then leaving it exposed to the air." Of this, Mr. Berry well says "in this country it has not become popular and it does not seem at all likely that it ever will." Yet he devotes six pages to its respectful consideration.

Division of the isthmus or excision of part of it is carefully discussed in Chapter XVI. but it is put aside in favour of unilateral extirpation or other measures.

Practically, our author's recommendations, as regards cases necessitating operative treatment, narrow themselves down to enucleation in cases of adenomata, and one-sided extirpation in most others. A criticism may be ventured that he writes of these two methods as if they were competitive operations, whereas they are adapted to wholly different cases. It is scarcely correct to say, as is done on page 257, "The removal of a goitre by a surgical operation

may be performed by one or other of two widely different methods." In a large minority of cases no sort of choice is left to the surgeon, and in the majority for which enucleation is practicable, it is often not the goitre, as a whole, which is removed, but rather an encapsulated tumour developed within it. Both these procedures are, in their various modifications, minutely and carefully described, and Mr. Berry's observations, being the result of large experience, will be of great value to operators. We cannot abstract them in any detail. The whole gland ought not, of course, ever to be removed, and, as a rule, a thyroidectomy of one half is sufficient to give full relief. Transverse incisions are said to leave the least conspicuous scars, but it is admitted that they give less room for the dissection. The muscles, if cut, are to be carefully united by buried sutures. The drainage tube is to be removed at the end of twenty-four hours. If there has been urgent dyspnoea, general anaesthesia is to be avoided if possible, and if demanded by the patient, is to be resorted to with the utmost care. Some expressions would lead to the belief that Mr. Berry would gladly dispense with anaesthesia as a general rule, and he insists strongly that these operations, with the exception of the skin incision, are not attended by much pain. It appears, however, on reference to his table of operations that chloroform was used in most of his own cases.

The work closes with the table of operations, to which we have just referred, and a most instructive and satisfactory document it is. It comprises one hundred consecutive operations for the removal of goitre, performed between February, 1894, and January, 1901, with a mortality of only one. Of these, little more than a quarter were "extirpations," and nearly three-fourths were "enucleations." In a very large majority in both sections the operation was on one side only, and in no case was the entire gland removed. The table is much more than a bare statistical record, and in most instances gives details which enable the reader to judge for himself as to the nature of the case, of the operation, and the ultimate results.

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## COLLEGE NOTES.

BY THE DEAN.

AT the July meeting of the Council thirty-nine names were added to the membership roll. During the past year there has been an increase of upwards of one hundred new members and subscribers.

\*       \*       \*

THE arrangements for the Special Course of Lectures during the Autumn Session are not yet quite complete, and the details as to dates, subjects, &c., must be awaited until the publication of the new Schedule next month. Meantime it may be mentioned that the following gentlemen have each undertaken one of the courses : Mr. Carless, Dr. Dundas Grant, Mr. Work Dodd, Dr. C. O. Hawthorne, Mr. Jackson Clarke, and Dr. J. M. H. MacLeod.

\*       \*       \*

THERE seems to be some misapprehension in the minds of some as to the attitude of this College in regard to members of our profession who are engaged in mission work abroad. More than a year ago the Council had this question before them ; it was unanimously resolved that they should be at all times admitted gratuitously to our lecture rooms and consultation theatres ; and that those who, being eligible, made application should be constituted honorary members of the College during the period of their home-leave.

\*       \*       \*

THE vacation course of Practical Classes during September is now arranged for.

The time-table prepared by Captain Pinch is published in this issue, and copies may be had on application at his office.

The Course opens on Monday, the 9th, and terminates on Friday the 27th September. An inclusive fee of five guineas confers the

right of attendance on all the classes, or individual classes may be taken at one guinea each. The course is made up as follows :—

(1) Applied Anatomy, conducted by Dr. Seymour Taylor and Mr. James Cantlie.

(2) Practical Otology, conducted by Dr. Dundas Grant and Mr. Richard Lake.

(3) Practical Laryngology, conducted by Dr. Jobson Horne.

(4) Practical Ophthalmology, conducted by Mr. Vernon Cargill.

(5) Clinical Microscopy, conducted by Captain Hayward Pinch.

(6) Examination of the Nervous System, conducted by Dr. Harry Campbell.

(7) Röntgen Rays, conducted by Dr. Harrison Low.

It may be well again to call attention to the fact that our practical classes are not reserved for members of the College only, but are open on the terms here stated to all duly qualified medical practitioners.

Considerable trouble has been taken in the arrangement of this condensation plan of work, and the Council trust that members will support the course, and do all in their power to bring in students from outside.

\* \* \*

IN connection with the proposed extension of the Laboratory work, and as part of the scheme for the formation of a small pathological museum, it is under consideration to remove a number of pathological plates from the Clinical Museum to the walls of the Laboratory. The most of these plates, however, are still unframed, and without a few paltry guineas this excellent suggestion cannot be carried out. Will some generous member not relieve the Finance Committee from its conscientious scruples, and solve the difficulty by defraying the cost ? The sum required is only from twenty to thirty pounds, and such an expenditure would be the means both of helping a much needed development of our work and of bringing to light many valuable plates hitherto hidden in the more or less inaccessible obscurity of portfolios and cupboards.

\* \* \*

CLINICAL Lectures for the Autumn Session have been promised by Sir William Broadbent, Sir W. Mitchell Banks (of Liverpool), Sir Felix Semon, Professor Markham Skerritt (of Bristol), Pro-

fessor Sims Woodhead (of Cambridge), Dr. J. F. Payne, and Mr. Brudenell Carter.

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THE Right Reverend the Lord Bishop of London has done the College the honour of becoming one of its Vice-Patrons.

\* \* \*

THE fixture card for Cliniques and Lectures during the September—December term of the year is rapidly approaching completion, and will be in the hands of members by the middle of this month.

The same arrangement has been adhered to as before. No suggestions have been offered as to alterations or improvements in the present scheme, which seems, on the whole, to be suitable and acceptable to the large majority of our members.

\* \* \*

As the College will be closed during the month of August, these Notes will not appear in the September issue of THE POLYCLINIC.

\* \* \*

THE total attendances at the College during the month of June amounted to 1,048. Twenty cliniques were held, at which the ailments of 121 patients were investigated and discussed.

\* \* \*

THE Council have agreed that the College shall not reopen after the recess until September 9.

\* \* \*

DR. J. E. SQUIRE and Dr. T. Kelynack are sincerely thanked for their kind contributions of books to the Library.

\* \* \*

IT is announced that again this year a medical excursion has been arranged in France for the purpose of visiting a certain number of the Spas of that country. These trips have been organised for several years and have proved their value by becoming annually more popular.

The tour this year is under the direction of Professor Landouzy, of Paris, is designed to occupy twelve days at an inclusive cost of

£12 10s., and the programme includes a visit to Aix-les-Bains, St. Gervais, Brides-les-Bains, Evian, and other health resorts.

Might not such a trip, another year, if not this, be arranged to similarly visit some of the watering places of Great Britain? A sufficiently large party could be made up by members of the Polyclinic, and it is certain that the railway companies and those in authority at the various health resorts would afford full facilities for such a tour being carried out efficiently and inexpensively. An energetic man with some capacity for organisation could readily carry out such a scheme and might make it, in time, the holiday feature of this College.

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#### CORRESPONDENCE AND ANSWERS.

DR. P.—**INTRAUTERINE TUBERCULOSIS.**—It may be taken as proved that tuberculosis very seldom develops in the foetus *in utero*. Neither in man nor in the lower animals have many instances occurred of the recognition of tubercular products in the body of the newly born. A few such are on record to prove the possibility, but they do not go further. Prof. McFadyean, of the Veterinary College, paid especial attention to this and offered a premium for calves born with tubercle. We are told that he obtained only four. It has been hastily assumed by more than one writer that this is an argument in disproof of parental transmission, and in support of the belief that the disease is usually acquired by infection after birth. In reality it implies nothing of the sort, for it is well established that the limits of latency of tuberculous germs are very wide indeed. It may be that these germs wait for months or for years until some exciting cause brings them into activity.

\* \* \*

A NOTE ON SWISS HOSPITALS IN 1817 AND 1901.—In the POLYCLINIC for May last there is an article on Medical Travellers, in which it is suggested that medical men visiting the Continent of Europe should make a point of examining the hospitals and dispensaries, and take notes of what they see there. Having recently during a week's stay in lovely Lucerne devoted a morning to going over the local hospital, and having at hand some unpublished notes taken in 1817 by my great-uncle, Dr. Leonard Gillespie, R.N., who served with Nelson in the *Victory*, and afterwards was Inspector-General of Naval Hospitals, I have thought that it might be of interest to the readers of the POLYCLINIC to have a short account of these two visits paid with an interval of eighty-four years.

Dr. Gillespie's notes were made in the course of an extensive tour through France, Italy, Switzerland, down the Rhine, Belgium and Holland, which extended over a period of ten months, and there being of course no railways or steam-boats

in those days, had to be made by hired coach or sailing ship, *diligence par eau*, as he calls it. He noticed carefully the condition of the countries through which he passed as to their conformation, state of agriculture, and condition of the inhabitants, as to whom he remarks that in the Vallais a great number of cretins or goitres came under observation, mostly females, a tenth part of that sex being apparently affected. In the museum at Berne he notes that there is a drawing of a femoral bone, apparently human, said to have been found in the Rhine, which exceeds three feet in length, and of which the dimensions are in proportion; the original is said to be in the museum in Lucerne, or Zurich. The person to whom it belonged, must, he says, have been ten feet in height. In the same museum he noticed some curious petrifications in the *grès* or freestone, and also a petrified nautilus of large dimensions. The hospital at Berne he describes as a fine establishment for aged citizens, 120 of whom are here comfortably lodged and fed: the wards are clean, well warmed and aired, and furnished; their food sufficient. Pensioners in a limited number are received for about 250 francs per annum, but the most original and truly patriarchal part of the institution, which, he says, does honour to Swiss hospitality, is a regulation which admits poor travellers to lodging and board for one or two days. The whole establishment, he says, seems well regulated, is situate in the most pleasant part of the town, is surrounded by pleasant walks, and dedicated "*Christo in pauperibus.*" At Basle he describes another hospital which he visited, well situate on a fine lofty terrace overlooking the river (Rhine), with a neat garden, the interior perfectly neat, clean and well-furnished; wards do not contain more than eight or ten beds each, with curtains and comfortable appendages; they have double doors and windows, and are well warmed by stoves and chimneys; the baths and kitchen are all in the best order, and the rations liberal. 110 patients were inmates at the time.

In June, 1901, I went over the Lucerne hospital, which contains 120 beds. It was built, according to an inscription on the walls, about 250 years ago. The wards are small, but are kept scrupulously clean, and the food seemed good and sufficient. In the two operating rooms I found full provision for the aseptic performance of operations. The nursing is done by fifteen nurses belonging to a Sisterhood, of whom one, the matron, does the dispensing. In the hospital grounds are fruit and vegetable gardens, producing sufficient supplies for the patients for the whole year. There is also a pleasure ground where roses flourish, and patients can sit or promenade at pleasure. Surrounding these grounds are rooms for the house surgeon, chaplain, and nurses, and also a certain number for convalescent patients. The growth of the town has surrounded the hospital premises with buildings, but a new hospital is being built on the pavilion principle, on a height near the town, to accommodate 200 patients and take the place of this one.

H. NELSON HARDY.

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LEPROSY IN GERMANY IN THE MIDDLE AGES.—In Germany, leper houses were chiefly founded in the 13th and 14th centuries. Many were probably general hospitals. It was at its height in the 13th and 14th centuries, and then began to decline. Vichow holds that there is evidence that "throughout Germany every town, every village, every cloister, had its leper house." The leper house was usually outside the town, the hospital for the sick might be in it. No details are forthcoming as to the number of inmates, and from many facts it would appear that usually they were small.

**DELAYED ERUPTIONS IN THE EXANTHEMATA.**—Arbuthnot says of small-pox: "The longer the eruption is a-coming, and the smaller when it comes, the disease is the less dangerous."—"On Aliments," p. 421.

This is a practical observation of much interest, and is probably well borne out by more modern experience. It is of especial interest in reference to the "suppression treatment" of syphilis now in vogue.

\* \* \*

**LEPROSY IN THE FAROE ISLANDS.**—A letter from Dr. Ehlers, of Copenhagen, referring to a note which appeared in our pages a month ago, informs us that it is quite certain that in former years leprosy did abound in these islands. He states that there was a lazaret house in Arge, and that a royal ordinance, April 29, 1661, spoke of the great number of lepers found in all places in the Faroe Islands, and believed to be increasing. The same ordinance directed that lepers should be isolated by force when found necessary. Dr. Ehlers adds that at the present time there are no lepers in the islands and that the disease appears to have been extinct since the beginning of the 19th century. The name Faroe, he tells us, should be spelt Fair, and means mutton. The islands were noted for their sheep. It is obvious that careful investigation of the conditions under which leprosy ceased to occur in the Faroes will be of great interest. An historical paper on this and other questions in relation to leprosy, by Dr. Ehlers, will form part of a forthcoming New Sydenham Society volume.

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**M.B.**—Consult Dr. Stone, on "Some Effects of Brain Disturbance in the Handwriting," *St. Thomas's Hospital Reports*, with facsimiles, vol. xii.

\* \* \*

**SENEX** sends us the following line as suitable to be inscribed over the Polyclinic Consultation Theatre: "*Morborum quoque te causas et signa docebo.*"

\* \* \*

**OOPHAGIST.**—The precept to which you allude is probably the following: "*Si sumas ovum, molle sit, atque novum.*"

\* \* \*

**TRANSMUTATION IN TRANSMISSION.**—The case published in "Crocker's Atlas," under the name of Psoriasis follicularis seems to be an excellent illustration of transmutation in transmission. The patient had a peculiar form of dermatitis which began as a Lichen, passed into Psoriasis and finally into Pityriasis rubra. It relapsed during her whole life. Her mother had psoriasis. No case could more forcibly illustrate the unwise of insistence on nominal diagnoses.

\* \* \*

It is generally believed that if an egg be pricked at its rounded end even with the smallest needle it will be killed. It is at this end that there is a collection of air, *Folliculus aeris*. The quantity of air accumulated here is said to be greater in those birds which are born well advanced in development than in those born forlorn and helpless. Thus the eggs of all birds which nest on the ground have a large air vesicle.

\* \* \*

**DODDER.**—Ivy is a climber only, not, like yourself, a parasite. It does not in any degree derive nourishment from the trees on which it grows. It is obvious that

it cannot get any from walls. It may be plausibly disputed whether it does any injury to the trees to which it clings, for it is often seen on very large ones. It is reputed to be wholesome for sheep and deer in spite of its rank odour, and pheasants are fond of its seeds.

\* \* \*

**LEPROSY IN IRELAND.**—Dr. C. F. Moore (Dublin) writes us:—“It is a common saying at Cork that ‘potatoes banished leprosy from Ireland.’” It is probable, however, that the malady was on the decline before Sir Walter Raleigh’s time. It lingered perhaps longer in Ireland than in England, but we are not in possession of any accurate facts as to the history of its decline. There were leper houses in Dublin, Cork, Waterford and other places.

\* \* \*

**URINARY ANALYSIS, &c., &c.**—We advise all our readers who are in the habit of examining urine and of making elementary analyses or bacteriological investigations, to write to Mr. Martindale, of 10, New Cavendish Street, for one of his “Price Lists.” Mr. Martindale deserves the thanks of the profession for the admirable cases which he has fitted up, and for the reasonableness of the prices at which he offers them.

\* \* \*

**PNEUMONIC PYÆMIA.**—At a recent meeting of the Northumberland and Durham Medical Society, in February, 1901, Dr. Murray demonstrated a specimen of pus from the knee-joint of patient, with lobar pneumonia, showing the diplococcus pneumoniacæ.

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**CATARRHAL PNEUMONIA.**—Flaxman, the sculptor, was 71 at the time of his death. He contracted a severe cold in church on Sunday, December 3, but was sufficiently well on the following Monday to receive a few friends at dinner. Medical advice was called in the same evening. He died a few days later.

The Danish Historian, Niebuhr, and many other distinguished men have died in exactly the same manner. A chill, a cold on the chest, and death after a few days. The usual condition is extensive consolidation of lung with perhaps some pleural effusion.

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**DERMATOLOGIST.**—For a recent and excellent account of the anatomy and physiology of the skin, see Dr. Duhring’s Part I. of “Cutaneous Medicine.”

\* \* \*

**POLYDACTYLISM.**—An important example of a nine-toed foot with dissection of muscles, &c., is given by Mr. Francis Mason in *St. Thomas’s Hospital Reports*, vol. ix., with woodcuts.

\* \* \*

**HORSE EXERCISE IN THE TREATMENT OF PHthisis.**—Sydenham, as is well-known, entertained a very high opinion of horse exercise in the treatment of pulmonary phthisis. “Neither mercury in syphilis nor bark in intermittents is more effectual than riding in consumption.” He insisted on the importance of prompt change of underclothing after such exercise. The bicycle does not probably quite take the place of the horse for riding exercise, but it at any rate makes such exercise available to many who could not otherwise obtain it.

# MEDICAL GRADUATES' COLLEGE & POLYCLINIC,

22, CHENIES STREET, GOWER STREET, W.C.

## SCHEDULE OF CLINIQUES AND LECTURES

From SEPTEMBER to DECEMBER 1901.

Cliniques at 4 p.m.

MONDAYS. (Skin)	TUESDAYS. (Medical)	WEDNESDAYS. (Surgical)	THURSDAYS. (Surgical)	FRIDAYS. (Eye, Ear, Nose, and Throat)
September 9 COLLEGE OPENS	September 10 Dr. W. Ewart	September 11 Mr. J. Cantlie	September 12 Mr. Hutchinson	September 13 Dr. Jobson Horne
September 16 Dr. J. Galloway	September 17 Dr. J. E. Squire	September 18 Mr. Johnson Smith	September 19 Mr. Hutchinson	September 20 Mr. R. Lake
September 23 Dr. A. Whitfield	September 24 Dr. Harry Campbell	September 25 Mr. P. W. De Santy	September 26 Mr. Hutchinson	September 27 Mr. Work Dodd
September 30 Dr. A. Whitfield	October 1 Dr. Seymour Taylor	October 2 Mr. R. Harrison	October 3 Mr. Hutchinson	October 4 Dr. H. Tilley
October 7 Dr. J. F. Payne	October 8 Dr. C. Theo. Williams	October 9 Mr. P. J. Freyer	October 10 Mr. Hutchinson	October 11 Dr. Dundas Grant
October 14 Dr. J. Galloway.	October 15 Sir W. H. Broadbent	October 16 Mr. A. H. Tubby	October 17 Mr. Hutchinson	October 18 Mr. Marcus Gunn
October 21 Dr. J. J. Pringle	October 22 Dr. James Taylor	October 23 Mr. J. Berry	October 24 Mr. Hutchinson	October 25 Dr. St. Clair Thomson
October 28 Mr. Malcolm Morris	October 29 Dr. Harry Campbell	October 30 Mr. A. H. Tubby	October 31 Mr. Hutchinson	November 1 Mr. R. Lake
November 4 Dr. Radcliffe Crocker	November 5 Dr. R. L. Bowles	November 6 Mr. J. Cantlie	November 7 Mr. Hutchinson	November 8 Mr. Treacher Collins
November 11 Dr. J. F. Payne	November 12 Sir W. H. Broadbent	November 13 Mr. E. W. Roughton	November 14 Mr. Hutchinson	November 15 Dr. H. Tilley
November 18 Dr. T. Colcott Fox	November 19 Dr. Seymour Taylor	November 20 Mr. Howard Marsh	November 21 Mr. Hutchinson	November 22 Dr. Dundas Grant
November 25 Mr. Malcolm Morris	November 26 Dr. W. Ewart	November 27 Mr. P. W. De Santy	November 28 Mr. Hutchinson	November 29 Mr. Ernest Clarke
December 2 Dr. J. Galloway	December 3 Dr. James Taylor	December 4 Mr. Reg. Harrison	December 5 Mr. Hutchinson	December 6 Dr. St. Clair Thomson
December 9 Dr. J. J. Pringle	December 10 Dr. Guthrie Rankin	December 11 Mr. Johnson Smith	December 12 Mr. Hutchinson	December 13 Dr. Dundas Grant
December 16 Mr. Malcolm Morris	December 17 Dr. C. Theo. Williams	December 18 Mr. J. Berry	December 19 Mr. Hutchinson	December 20 Mr. N. MacLennan

## Clinical Lectures at 5.15 p.m.

1901.  
October 2nd and 9th—Sir FELIX SEMON, M.D.,  
F.R.C.P.  
October 16th—R. BRUDENELL CARTER, Esq., F.R.C.S.  
October 30th—Sir WM. H. BROADBENT, Bart., LL.D.,  
F.R.S.  
November 13th—Prof. G. SIMS WOODHEAD, M.A., M.D.,  
of Cambridge.  
November 27th—Prof. G. MARKHAM SKERRITT, M.D.,  
F.R.C.P., of Bristol.  
December 4th—Sir W. MITCHELL BANKS, LL.D.,  
F.R.C.S., of Liverpool.  
December 18th—J. F. PAYNE, Esq., M.D., F.R.C.P.

## Special Courses of Lectures at 5.15 p.m.

1901.  
October 11th, 18th, and 25th—Dr. J. M. H. MACLEOD,  
“Some observations on the Histo-Pathology of  
Skin Disease.”  
October 14th, 21st, and 28th—Mr. H. WORK DODD,  
“Some practical points in the examination of the  
Eye, not including Refraction.”  
November 8th, 15th, and 22nd—Dr. J. DUNDAS GRANT,  
“Nerve Deafness: its varieties, diagnosis, and  
treatment.”  
November 11th, 18th, and 25th—Mr. J. JACKSON  
CLARKE, “The Protozoa in Pathology.”  
December 2nd, 9th, and 16th—Mr. A. CARLESS, “The  
Surgery of the Stomach.”  
December 6th, 13th, and 20th—Dr. C. O. HAWTHORNE,  
“Medical Ophthalmology.”

# THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES' COLLEGE, LONDON.

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VOL. V., No. 3.—SEPTEMBER, 1901.

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## LEPER HOUSES IN THE MIDDLE AGES.

IN his address at the recent Tuberculosis Congress, Professor Koch is reported to have encouraged his audience to hope for the extinction of tuberculosis, by appealing to what had been effected in the case of leprosy, through the prevention of contagion.

All who are acquainted with the facts, as to the disappearance of leprosy from the greater part of Europe, will regret much to see an authority such as Professor Koch thus reaffirm the often confuted fallacy that it was brought about by segregation measures. If those who hope for the extermination of tuberculosis by preventing its spread by contagion have no firmer ground than this, they are, indeed, building upon sand. The iteration of such a fallacy is conceivable only in a partisan willing to avail himself of anything which may seem to give support to his theory regardless of its truth, or of one who has never studied the facts and bases his assertions on mere hearsay. It is, of course, in the latter category that we place Professor Koch.

We will endeavour to state the facts clearly, and in doing so must invite the reader to make legitimate use of his imagination and try to picture for himself the social conditions of the times concerned. Leprosy was at one time prevalent over the whole of the continent of Europe and all its adjacent islands. The islands, perhaps, suffered more than the mainland, but it probably occurred

more or less everywhere, and nowhere was it reputed to be specially endemic. Its universal prevalence would denote that, if its only means of spreading was by contagion, then it must have been very contagious. It was not a disease of the poor only, for ladies, priests, nobles, even occasionally kings, were its victims. Yet, though so widely spread, only a very small minority suffered. We have no information as to its origin, but probably it had prevailed from time immemorial, and scarcely any traditions exist as to its introduction into special localities. It culminated, probably, about the time of the twelfth or thirteenth centuries, or any rate, more attention was given to it about this time. A legend has been invented that the return of the Crusaders from Palestine was influential in its spreading, but this is probably based upon the circumstance of its being a biblical malady. It is quite certain that leprosy was present in Europe long before the Crusades, and it is not very probable that many of the returning soldiers found their way to Iceland, the Faroes, or the inhospitable coasts of Norway. To think that they were the means of its dissemination, on any large scale, is to suppose that the disease is one as contagious as syphilis, which most certainly it is not. Then, as now, leprosy was a chronic malady lasting through many years and becoming, possibly, more contagious the longer it lasted. Then, as now, it was an insidious disease, the early stages of which were difficult of recognition. Then, as now, its diagnosis, even in the later stages, was very liable to error, and cases of psoriasis, leucodermia, lupus, &c., might easily be confused with it. Now it is unquestionable that about the time referred to, and later, many benevolent persons, under the influence of the Christian doctrine, which was then at its height, were moved to found homes for lepers. Leper Homes became common. To those for whom a *post hoc* is sufficient it may certainly be granted that the multiplication of leprosaria and the decline of leprosy appear to have been coincident. Other facts have, however, to be taken into consideration before we jump to the conclusion that this result was due to the prevention of contagion, or in any way consequent on isolation.

We have now reached the point at which we must ask our readers to think with candour, and to use their best endeavours to form a clear mental picture of the actual facts. They must keep in mind that the alleged contagion of leprosy must be insidious and

under some conditions certainly very potent. An exceedingly slight exposure to risk must suffice to convey it, and apparently no predisposing conditions are requisite in the recipient. When a European visiting a leper district acquires the disease it is very seldom that he is aware of having encountered any exposure whatever. If therefore, such a disease is to be trodden-out by isolation measures, such measures must be complete and continuous. Now it is quite certain that the Leper Homes of the middle ages did not attain anything approaching to complete segregation. More than that, it is quite certain that they did not attempt it. They were refuges into which it was a privilege for the patients to obtain admittance, not places of detention into which they were compelled to go. The popular imagination is occupied by stories in prose and poetry of the outcast leper and of the fearful ceremonies by which he was compelled to renounce the world and pledge himself to seek no intercourse with his fellows. That such ceremonies may have been used occasionally, and in some districts, we do not doubt, nor that in almost all countries a leper in an advanced stage of disfigurement was usually shunned and regarded with loathing; but in every country where leprosy has prevailed, the instincts of human nature have in the main triumphed over both disgust and fear, and family affection, the desire of gain, and the love of an idle life, have each in turn induced healthy persons to associate without precaution with the sick. The proof of these statements is to be found in every page of the records of mediæval lazars houses. In that of Troyes healthy women were employed as nurses, and it is on record that at a visitation in 1575 three of these were found to be pregnant, and in the case of one of them it was for the second time during her residence of ten years. The same woman was accused of having brought prostitutes into the home. A male leper of the same home who was convicted of immorality at a public house was flogged and banished for five years. At many leper homes the punishment for breaches of discipline was simply expulsion, and the delinquent was sent to wander through the country. There would seem, indeed, to have been but little concern as to the peasant population. The leper homes were for the towns, and in many cases only those who could prove their parish settlement had any claim to be admitted. At Paris, with an unimportant exception, no one could be admitted

into St. Lazare unless the legitimate offspring of citizens and born within the four gates of the city. At Nismes a stranger had to obtain the approbation of the Consul and pay a sum down. Indeed, at most lazar houses some payment was required, and the poor were at a disadvantage. So strictly were parochial qualifications demanded that it is on record that a Duke of Burgundy failed to obtain from the authorities at Lisle admission for the servant of one of his friends.

In the year 1508, John, King of Denmark, ordered, respecting the leper house of St. George at Copenhagen, that the alms collected "be distributed to all the inmates of the hospital, in such a manner that the sick receive more than the healthy inmates." It is presumable from this that there were in the hospital not only lepers and other sick persons, but a certain number of poor who were not counted as sick.

The same King John of Denmark, having had complaints made to him as to the ill-management of a leper house at Naevsted, gave order that the rector of the parish and after him his successors, "shall employ women to nurse the sick, who shall watch over them and take charge of their food, clothing and washing, and hold themselves entirely at their service." Not a hint is given as to any risk run by these nurses; nothing is apparently thought of but the comfort of the patients. In the same edict we read, "From this day forward no new healthy brother shall be admitted to the convent, but all the sick brothers who come from the district paying tribute to the convent must be received into it." Clearly admission was a matter of charity and favour, and by no means of compulsion.

Respecting the hospital at Svendborg under date 1436, we find the following, "The income shall be divided equally among the sick brothers and sisters and the eight healthy brothers and sisters, these latter being charged with the care and maintenance of the sick." We infer from this that the number of patients was usually about the same as that of their attendants. It is one of the exceedingly few instances in which women lepers are mentioned. In the case of another hospital in which the numbers of the sick and healthy are given, they were just equal. At this same hospital it is clear that both the attendants and the patients had their wives

with them. One of the enactments ordains, "If any of the eight healthy brothers loses his wife, he must never marry again. . . . but will be expected to remain chaste as beseems a monk." Further, "The sick may not marry again if his consort dies, unless some one consents to share his fate." Thus it is clear that the remarriage of a leper was not thought wrong, nor the admission of his healthy bride into a leper's home.

It is to be kept in mind that the decline of leprosy in Europe was general, universal, and almost simultaneous. There were significant exceptions to these statements, but for most part they are true. Nor after the decline had set in was there any relapse. It did not linger here and there, in out-of-the-way and neglected places, but it vanished by a sort of slow melting away from all. In the course of a few centuries, France, Germany, Sweden, Denmark, the British Isles—including Ireland, the Orkneys, and the Shetlands—were free. They were absolutely free, not a case remained, and they have continued free ever since. Although into most of these countries numerous cases of leprosy have since been imported and, for the most part, no precautions observed, the disease has never shown any tendency to again become endemic. Its decline was apparently much hastened by the Reformation, and the final closing of the leper houses was delayed a century or more in those countries which still adhered to the old faith; in some of them, Spain and Italy for example, it lingers yet.

We venture to insist that it is absurd to imagine that in the Middle Ages there existed anywhere a medical police of sufficient skill and sagacity to effect the isolation of lepers. The absurdity of such a supposition is increased a thousand-fold if we realise that these impossible conditions must have been existant, not only in a few populous cities, but systematically arranged over the whole country. Leprosy was not concentrated anywhere but was met with sparingly over the length and breadth of the land.

There is plenty of evidence to show that when leprosy was declining the attempts at isolation, such as they had been, ceased. In proportion as the victims diminished in numbers so, naturally, would the fear of it decrease, and we may safely believe that in almost all instances the last leper of the district was allowed to recover at home or to die quietly amidst his family. If he had

preferred to seek the hospitality of a leper home he would usually find himself by no means solitary and perhaps scarcely shunned. With him there would be those sick of other chronic maladies and some who were merely indigent. It is on record that at one leper asylum, when the number of legitimate applicants fell off, blind persons were admitted to occupy the beds. When a leper died in a home his clothing, bed, and all his belongings became the property of the community which had sheltered him, and we do not meet with any hint that such articles were destroyed; on the contrary they appear to have been thought a valuable perquisite.

Had there been no other influence at work in effecting the extinction of leprosy than the prevention of contagion by systematic seclusion of lepers, it is impossible that the decline should have been general. However zealous some districts might possibly have been, others would have been supine, and thus foci of disease would have been maintained.

In all seriousness we again ask, is it conceivable that in all these countries, distant from each other and diverse in customs, any measures of isolation could have brought about the simultaneous and uninterrupted decline of such a disease as leprosy? Does it not amount to a certainty that some unsuspected influence was at work alike in all countries, which was slowly but surely putting an end to the still unrecognised cause of the malady? Do not the facts point irresistibly to the conclusion that that influence must have concerned the food of these various peoples?

Finally let it be noted that, as regards the provision of homes for lepers, the places in which the disease has lingered were no whit behind those from which it has disappeared. Bergen has one of the oldest and certainly the largest leper home in the world, yet the disease still prevails in Norway. Spain and Italy had their leper houses and they still have lepers. Of Crete, in which lepers still abound, Dr. Ehlers (to whom we have been indebted for several of our quotations), has just written, "*de temps immémorial il est de coutume en Crète d'isoler les lepreux.*" It is, of course, true that in these places the isolation has never been complete; but neither had it ever been one whit more nearly complete in any of the places from which the disease has vanished.

## CRETE.

THE beautiful Island of Crete has for ages had a bad repute as to leprosy. The disease has always been common there, and it has persisted in spite of measures for its repression. One part of its population, the Sphakiots, have, however, it is believed, always escaped, and they are on the most recent testimony, exempt at the present day. These Sphakiots are of the same mixed descent as the rest of the population, but have acquired almost racial peculiarities by living in the mountains. They are Highlanders, and being brave soldiers, have never submitted to the Turkish rule. The total population of Crete is a little more than 200,000. About 40,000 are Mohammedans, but most of these are Cretans and not Turks. Greek is the language universally spoken. Candia, Canea and Retimo are the only towns of importance and are all on the coast. There are no rivers, and by far the greater part of the surface of the island is occupied by mountain ranges. Excellent fruit is abundant, there is good pasturage, and there ought to be no scarcity of food, but bad government and wars have so far impoverished the country that a large part of the population live in great poverty, subsisting chiefly on olives and bread. Bread dipped in olive oil with a little strong wine is the principal diet of the poor, but snails, mussels, crustaceans and fish are also eaten. It may be remarked in passing, that as the fasts of the Greek Church exclude fish as well as flesh, there will not arise that special demand for this article which occurs everywhere under the Roman Catholic *régime*. This may be of some importance as regards the immunity of the Sphakiots. At a great distance from the coast, they would get no share of the produce of the sea in a fresh state, and not being allowed to eat fish on fast days they would be under no temptation to import it in a dried state into their mountain villages.

Respecting the prevalence of leprosy we find the following in Hirsch :—

“ But the chief seat of leprosy in this part of the Mediterranean is Crete. An examination made there in 1833, of persons notoriously leprous, gave a total of 628, of whom 522 were in the province of Candia, 64 in Retimo, and 43 in Canea ; but many more patients who had only lately become leprous or who had been hidden by their relatives, remained uncounted. We shall not go far wrong in

following Smart and placing the number of lepers living on the island at 900, giving a ratio of 3·6 per thousand of the population. A more recent report by Brunelli confirms this."

Recent numbers of our contemporary "LEPRA" have contained an excellent and elaborate report on the present condition of Crete as regards leprosy, by Drs. Ehler and Cahnheim. These gentlemen visited the Island as a commission of enquiry and had every assistance from the Government, and the result is a document of very high importance. To this we propose to revert at a future time.

Some not unimportant facts as to the manner in which segregation was carried out in Crete during the latter part of the last century are given by Captain Spratt.<sup>1</sup> He writes :

"This day there were eleven lepers waiting at St. George's Gate for the charity of passengers, and as they were an interesting group I stopped to make some inquiries of them, which they freely answered."

After describing one of the worst cases, an old man who occupied a hut by himself, he continues :

"Sad and singular it was to learn that he had only been joined by his daughter about ten days previous. She at the age of eighteen, and leaving a mother behind, had then, at the age of hope and promise, been driven from her village home for ever, to be an outcast from friends and relations, in companionship, and with the stigma of a leper. . . . On first seeing her, although seated amongst the unmistakable lepers, I could not believe that she was one of them, being of considerable beauty though pale. . . . I was induced therefore to ask if she really was a leper. She immediately showed me her hands, still delicate and fair, but with two of her fingers slightly bent and stiff. These symptoms, unmistakable to those who know the early appearance of the disease, had only appeared on her about six months previously, when she was immediately placed under the surveillance of the matrons of the village, who then jealously watch any suspicious spots, from a general belief in its contagious nature. The signs of the malady becoming more developed and evident during this time, together with the fact of her father being also a leper, were considered decisive. She was consequently now driven from her home, to become for ever the companion of corruption and misery. . . . By the side of the girl were seated two lepers, man and wife, who had had a child, now six or seven months old, and lying in the arms of the latter, and which had been born to them after being married and residents in the leper village eight years. I learn that about seventy families compose this village, of which thirty-two are Turks, numbering in all 111 persons. . . . 'To be put under the ground would be better than life' was the feeling reply of one poor woman with whom I had exchanged a few words."

These statements well illustrate the zealous, but at the same time most inefficient, endeavours to enforce isolation, which have

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<sup>1</sup> "Travels and Researches in Crete," by Capt. T. A. B. Spratt, F.R.S.

characterised most modern efforts in that direction. The precautions taken for the detection of early cases have probably not been surpassed in any community. In Europe in the middle ages, as we have seen, they were not even aimed at. Yet leprosy still prevails in Crete, whilst it has wholly disappeared from almost every part of Europe. That in spite of the zeal in the detection of lepers the isolation enforced was wholly inadequate to prevent the spreading of a contagious malady may be inferred from the facts that the occupants of the village were in "families," which doubtless comprised some healthy individuals, and that even the worst cases were allowed to leave the precincts, and to beg of, and converse with, passers-by.

In describing the horrors of another leper village which he inspected, Capt. Spratt expressly states that no healthy persons ever entered it. There was, however, a healthy Cretan Turk located there with his leper wife. He was the only untainted inhabitant. "He had resided with his wife for several years without becoming a leper likewise, and consequently had the privilege of free access to his mosque and to the neighbouring cafés. Capt. Spratt adds :

"The ignorant Cretans attribute the prevalence of this disease in their island in a great degree to impurity of habits (*i.e.*, syphilis), and hence their extreme disgust at it; but the educated, perhaps more rightly, attribute it to the great consumption of oil with their food; it being the principal produce, and cheap, is in consequence largely used by all, either pure or with the olives, which *with salt fish, often rancid, and of the worst sort*, and bad cheese, constitute the principal portion of their diet."

This definite statement as to the use of bad salt fish is of especial value, because a more recent medical visitor and high authority on leprosy has roundly asserted that not much fish is eaten in Crete.

Nowhere perhaps have we stronger evidence of belief in contagion and of desire to isolate than in Crete. Yet let us note the inconsistency which even here attended the attempts which were made in this direction. The author whom we have just quoted informs us that when he visited one leper village (that Jerapetra) "most of the stronger portion of its population were absent." What were these sufferers from a supposed contagious disease doing? "It was harvest time and they were gleaning charity from their native or neighbouring villages and friends."

## THE EVOLUTION OF MAN.

MR. MACNAMARA, in his Hunterian Oration, took a bold position in reference to the evolution of man, and we owe him our best thanks for his outspoken courage and for his insistence upon the importance of the doctrine from an educational point of view. When, however, he proceeded to argue that it was the tendency to too early ossification of the skull in apes and monkeys which hindered the growth of their brains, he laid himself open to the suggestion that he was yoking his horse behind the cart. Surely he was forgetting the great maxim of the great man in whose honour he was speaking, to the effect that function precedes organisation and not the reverse. Although at first sight it may seem strange that the growth of a soft substance such as the brain can modify the shape and dimensions of its hard bony case, yet there are plenty of facts in nature which help us to conceive it to be true.

We have doubtless to seek the causes of the growth of the human brain in those which have influenced its activity, not in any which have exempted it from circumferential compression. Of these causes, probably by far the most important has been food. Given inducements to mental activity and a plentiful supply of suitable food, and the miracle is accomplished. When the bees wish to develop a worker into a queen they supply the larva with stimulating food, and everything follows as they wish. The facts as to the use of nervine stimulants in prehistoric periods would be most interesting and important if they were obtainable.

We have been told that the poets are always in advance of the naturalists and men of science. It is indeed their vocation to be so, for they base their imaginings on the general observation of mankind and do not wait for categorical proof. They pursue the deductive rather than the inductive method. We have possibly an instance of this non-scientific but yet most suggestive kind of reasoning, when Mr. Browning makes Caliban acknowledge, in the midst of his theological disquisitions, the pleasure of making "the brain become alive" by means of stimulants :—

"Look now, I melt a gourd-fruit into mash,  
Add honeycomb and pods. I have perceived,  
Which bite like finches when they bill and kiss—  
Then when froth rises bladdery, drink up all,  
Quick, quick, till maggots scamper through my brain."

It may be nothing more than a very wild conjecture—some may perhaps suggest an immoral one—that a chief aid in the development of the human brain has been alcohol, and that it was the discovery of fermentation which gave the ape-man his first impetus in a career of civilisation as the result of brain growth. The acquisition of the faculty of speech was no doubt a step of the very first importance in intellectual progress, but who shall tell us under what influences the germs of that faculty grew. No one can doubt that alcohol, used in moderation, by favouring the dilatation of the cerebral vessels, augments the flow of ideas. By thus, in Browning's expression, "keeping the brain alive," it may be assumed to favour its growth. Nor are facts of a certain kind wholly wanting in support of such a conjecture. All races of mankind have been in possession of some kind of alcoholic stimulant, or if there be any which have not they are precisely those which have remained most nearly stationary. Roughly speaking, the nations which have progressed to the highest point have been those which have been longest in possession of a liberal allowance of food, and of wine or some equivalent for it. Numerous other nervine stimulants other than alcohol have to be taken into account. Respecting some of these, tea, coffee, cocoa, &c., it is by no means proven that they are not also nerve-nutrients in the highest sense.

The suggestion that alcohol and its congeners may have been causes of brain development is not so subversive of ascetic morality as might appear at first thought. Many agencies have in the past conspired to aid human progress which it may be very undesirable to perpetuate. An ugly scaffolding is necessary during the building of a beautiful church, but, the church once built, the scaffold may be taken down. So it may be that the brain having attained its growth under the influence of physical stimulants we may now find it the highest wisdom if not to dispense with them, at any rate to greatly restrain their use.

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## HEALTH CONDITIONS IN SWAZILAND.

THOSE who may take the trouble to refer to the Maps which we published in July<sup>1</sup> will find Swaziland named only in that of South Africa. It is on the eastern slope of the northernmost extremity of the Drakensberg range and west of Tongoland and the southern corner of the Portuguese territory. The following extract is from a letter by Mr. H. D. Longe, now resident in Basutoland, published in the *Times* of August 28.

Swaziland is bordered on the north and west by the Transvaal, on the east by Portuguese territory and Zululand, and on the south by the Transvaal and new Republic. It is only some 8,000 square miles in area, but its physical and climatic features are extremely varied.

On entering the country at Darkton by one of the usual routes from Charles-town or Barberton one cannot help being impressed by the grand mountainous scenery. Here we are at a height of 5,000ft. above the sea level, the air bracing and the climate healthy. Malaria is scarcely known. Horses, cattle, and sheep thrive. The land is extremely fertile, and, but for the somewhat extravagant display of Jupiter's wrath and thunderbolts during the rainy season, which usually lasts from September to February, this part of the country is a decidedly desirable place to live in. Going a few miles further north to Pigs Peak and Forbes Reef, the seat of the principal gold-mining companies, the scenery is even more enchanting and the climate better. The district of Swaziland is a continuation of the high veld of the Transvaal, Lake Chrissie being only a few hours distant. From Darkton going eastward into Swaziland we pass on to the Babaan River, noted for its alluvial tin. A fine healthy spot, well watered, and eminently suited for a European settlement.

From here the road to Bremersdorp, the present township, is one continuous descent—a drop in a distance of 40 miles from 5,000ft. to 2,000ft.—truly a “decensu Averni”—from a healthy and pleasant climate to discomfort and malaria.

Bremersdorp is situated in a hollow surrounded by low undulating hills. In the distance rise the M'Dimba Mountains, and far away to the east the long range of the Lebombo, the border of Portuguese territory, while nearer lie the deadly Lebombo flats—during the rainy season a hotbed of malarial fever.

The nearer the east coast the more deadly becomes the fever, till it reaches its climax in Delagoa Bay. Bremersdorp, which is 90 miles from Piseni, the nearest station on the Delagoa Railway, is said to be on the edge of what is called the fever belt; and though the type of malaria from which a very large percentage of the inhabitants during February and March suffer is not deadly, still it is sufficiently malignant to reduce the sufferer very considerably in weight in an astonishingly short time, and to render life for some months a decided burden.

Some charitable people whose lot it may be to pay only a flying visit to this district of Swaziland are fond of attributing the cause of this fever to the unwise

<sup>1</sup> See p. 42.

consumption of alcohol, but proofs are by no means wanting to show that in the case of the most temperate this malarial fever is no respecter of persons.

Nor are the natives exempt. As we go east from Bremersdorp over the low-lying bush veld we cannot help noticing the gradual deterioration of the race morally and physically. In the higher lands the people are of fine physique and mental vigour, while their less fortunate brethren who inhabit the malarial districts appear to lose all the manly qualities instinctive in the Zulu races. Their huts are scarce fit to be called shelters, and they lack energy to cultivate crops more than barely sufficient, in an ordinary year, for their subsistence, and if a bad year befall them many die of famine and the rest are dependent for their food on the edible roots which they dig up on the veld. But these lowlands of Swaziland do not deserve an unqualified condemnation.

In winter the climate is quite healthy and the Lebombo flats, so deadly in summer, become the delight of the sportsman. Here may still be found antelope and winged game in abundance, and the roar of the lion is still to be heard breaking the silence of the night.

In winter the Boers have been in the habit of driving thousands of cattle and sheep into this low-lying country to protect them from the cold of the high veld and to graze them on the luxuriant grass, and from here they emerge in the spring in the best of condition.

With the annexation of the Transvaal Swaziland will henceforth come under British rule, much to the advantage of the Zulus who inhabit it. Mr. Longe is emphatic in his condemnation of the site of Bremersdorp, the present capital, and urges, with much reason, that a new site should be chosen in a higher and more healthy locality.

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## IS BOVINE TUBERCULOSIS COMMUNICABLE TO MAN?

PROFESSOR BAUMGARTEN, of Tübingen, has published an article in support of the opinion that bovine tuberculosis is not communicable to man. He cites as evidence a statement that a colleague of his, Dr. Rokitanski, some twenty years ago, inoculated a number of human beings, who were the subjects of incurable cancer, with tubercle from cattle. Although it was done very freely in no case was there any result although, as is stated, some of the patients survived several months. As may be inferred from what we wrote last month we are not amongst those who are reluctant to accept Koch's recantation. On the contrary we are quite prepared to believe that the difficulty in communicating tuberculosis by milk and meat is such that, for practical purposes, it may be wise to ignore

it. Still candour compels us to admit that this new item of evidence by no means settles the question. If the failure of a few inoculation experiments can be held to be conclusive, the non-contagiousness of Leprosy ought to have been accepted long ago, for numerous trials by different investigators have been made and all with negative results. Yet there are some who are not convinced. Rokitanski's experiments prove that the bovine bacillus does not readily implant itself in the human tissues. They are not concerned with tuberculous food and they leave aside the possibilities which the known facts as to the possible long latency of this curious parasite introduce. We repeat they go to support the conclusion that infection of man from oxen is difficult, but they by no means prove that it is impossible. In continuation of this subject the following items may interest our readers :—

#### ITEMS FROM A DEBATE AT THE TUBERCULOSIS CONGRESS.

We have condensed the following items from a report, given in one of our contemporaries, of what took place at one of the meetings of the recent Congress. They well illustrate the need for patience and for further work before we allow ourselves to urge upon the public any positive conclusions :—

Mr. Headley thought that Professor Koch's announcement had put the clock back twenty years.

Mr. Brechin said that it was well to remember that Professor Koch might be right, and that the treatment of this subject should not be too drastic.

Professor Ricardi remarked that in adults tabes mesenterica was secondary to pulmonary phthisis and yet meat formed the chief food of the adult. There must be no scientific doubt on any question on which they asked Parliament to legislate.

Mr. Cooper advocated a more natural open-air life for the cows and cattle as being conducive to the best health.

The Agent-General of New Zealand said, with regard to the open-air treatment of cattle, that tuberculosis was a great pestilence in Queensland and New Zealand where the herds were out of doors all the year round.

Mr. W. Field, M.P., from an exhaustive study of statistics, found that tuberculosis as a human disease had decreased by 50 per cent. whereas the amount of meat during the same time that had been consumed by the population had been trebled, and he could not see much communicability of tuberculosis through the agency of meat in the face of that fact.

Mr. William Duthie strongly objected to the plan of condemning a valuable carcase for some very small tuberculous lesion, for there was no danger from the meat of such a carcase.

Professor Dewar said that the suppression of tuberculosis in his herd was the most profitable thing that a breeder could attempt. Very little faith, he remarked, was now put in the hereditary transmission of tuberculosis.

Mr. W. Bunting said that four-fifths of the inspections of cattle were done by men who knew nothing about it and that the remaining fifth was done by those who knew too much.

Mr. J. F. Lloyd said that it was absolutely impossible to make cheese from sterilised milk. He added that persons were always too ready on insufficient evidence to attribute tuberculosis to the milk supply. In large towns want of sanitation was a more potent factor in its causation than the quality of the milk.

Sir George Brown, the President, sympathised with the butchers in the injustice to which they had occasionally to submit in regard to the question of seizures. He had called the attention of the Royal Commission to the waste of good meat unnecessarily in this matter.

Mr. Potter wanted to know, in view of the vastly different opinions held by authorities, what education they were going to give the people.

And finally

Colonel Nunn referred to the universal acknowledgment that it was desirable to eradicate the disease, leaving the matter of communicability out of the question.

## SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

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### ABSTRACT OF A LECTURE ON CHRONIC INVALIDISM IN WOMEN, ITS CAUSES AND CURE.

BY W. S. PLAYFAIR, M.D., LL.D.

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IN his introductory remarks Dr. Playfair alluded to the frequency, and to the disastrous effects—both personal and domestic—of the conditions included within the title of his lecture. These circumstances were in themselves a sufficient justification for asking careful attention to the causes and treatment of invalidism in women. Such names as hysteria, nervousness, hypochondriasis, and neurasthenia are sufficient to indicate the kind of cases with the prevention and cure of which the lecture was mainly concerned.

In dealing with prevention it has to be remembered that these nervous states are mainly found in the cultured and educated classes, and that they are apt to be developed by injudicious education and training, more especially in those who inherit a mobile and ill-balanced nervous constitution. The invalid woman is often the product of the wrongly trained girl. Hence the importance of conditions which develop the "corpus sanum," for with this there will probably be found the "mens sana." Unfortunately the higher class of mental training for girls is often associated with conditions very much opposed to physical health. It is not mental work *per se* that is injurious. The harm arises when this is not accompanied with suitable outdoor exercise, such as golf, hockey, tennis, rowing, &c.

It will generally be found that though the causes of neurasthenia are very numerous, defective nutrition and some form of mental

or emotional disturbance play an important part in every case. Work and even hard work is beneficial rather than otherwise to the healthy. But mental strain when the general health is depreciated and nutrition is below par is calculated to lead to disaster, and it is these circumstances which frequently bring about the development of neurasthenia.

The method of treatment originated by Weir Mitchell is the most generally successful way of dealing with these cases. But it needs to be carefully and thoroughly applied. An element of some importance is the personality of the medical man. A nervous, emotional woman is a difficult subject to deal with, and to gain her respect and regard is an essential of success. The nurse is hardly less important. Kindness, sympathy, intelligence and firmness are all required, and, at least in difficult cases, it is only the *rara avis* in possession of these qualities who will succeed. A frequent cause of failure is the attempt to carry out the treatment "in a modified way" so as to meet the objections of the patient or her friends. This endeavour often means the exclusion of some essential part of the treatment. It is, for example, a *sine qua non* that the patient shall be removed from her home surroundings, yet often an attempt is made to practise the treatment at home and to allow the occasional visits of relatives or friends. Almost invariably the attempt ends in failure.

The rest cure has two aims; the one, restoration of health to the body, the other to restore the balance of the nervous system. In the great majority of neurasthenic patients the general nutrition is in a wretched state, and in some the patient has the appearance of a living skeleton. It is no good *telling* these patients to take food. Something must be done which will secure nutrition independently of the will of the patient. That something is massage, which produces muscular nutritive change, and thus enables the patient to take food. The patient is kept in bed, and by degrees this muscular activity is brought about until massage is practised at least two hours twice daily. The test of the massage being well done is not the employment of high-sounding and misleading names which only serve to obscure a very simple thing, but the bestowal on the patient of the capacity to take large quantities of food. It is astounding to find the quantities of food these patients

can enjoy and assimilate. After a day or two of nothing but milk, a patient kept absolutely at rest in bed will be found to consume in addition to four or more pints of milk daily, a substantial breakfast, lunch and dinner, and to gain weight accordingly.

The psychological aspect of the treatment is as important as the physical. Here comes in the necessity of removing the patient from the influence of well-meaning but injudicious friends, and of excluding her from all communication with her relatives, at least for a time. After six weeks or so in bed the patient may get up for a few hours daily, and attended by the nurse should walk out and begin to attend church, concerts, theatres, &c. When possible, it is very desirable that before returning to her former surroundings she should be sent away with a proper attendant on a sea voyage or to the seaside or the country. Horseback exercise or bicycling is to be encouraged. The main objection to this method of treatment is the expense involved. That unfortunately cannot well be avoided. It is, however, less expensive than prolonged and constant ill-health, and from this it offers a considerable chance of certain and permanent escape.

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#### ABSTRACT OF A LECTURE ON THE TREATMENT OF STRABISMUS IN CHILDREN.

BY PRIESTLEY SMITH, M.R.C.S.

IT is important that the family practitioner should have a clear idea of the nature and treatment of strabismus, because the condition is one which inevitably comes under his notice, and it is to him that the first appeal for advice is addressed. The importance of such knowledge is increased by the consideration that much harm to the child is likely to result from delay in the selection and application of appropriate methods of treatment. It may be that the details of the treatment are for the most part carried out by the ophthalmic surgeon, but the determination of the date at which the necessary measures shall be undertaken is a responsibility which rests usually with the general practitioner.

The nature of the usual convergent squint of childhood is appreciated through a study of the nervous mechanisms which control the movements of the eyeball. These include centres which secure convergence and other centres by which conjugate movements are effected. In convergent squint there is excess in the action of the converging centre. This tends to turn both eyes sharply inwards. To endeavour to overcome this the conjugate centre comes into action and moves one of the eyes into a position looking straight forward. But this involves further movement inwards of the other eye, which is therefore made to squint. There is no fault in the muscles or nerves, but an excess in the action of the converging centre, this being overcome in the case of the one eye and aggravated in the case of the other by the influence of the centre producing conjugate movement. If the two eyes are equally good the patient will sometimes use one eye to look at an object and sometimes the other, the non-fixing eye in each case being turned inwards. That is, the squint will be *alternate*. On the other hand, if the usual efficiency of one eye is defective the patient will habitually fix with the good eye and squint with the defective one.

What is the cause of this excess in the activity of the converging centre? In at least 90 per cent. of the cases it is hypermetropia. Accommodation and convergence both occur in looking at near objects, and under normal conditions they take place *pari passu*. But in hypermetropia the effort of accommodation is always necessary, and there is therefore a continual tendency to the associated movement of convergence.

The condition of the refraction demands excess in accommodative effort, and with that goes excess in convergence. Correct the hypermetropia by the use of suitable glasses—that is remove the necessity for undue accommodation—and, at least in many cases, the excessive convergence, that is the squint, will disappear. But if this is true it may be asked why do not all children, the subjects of a distinct degree of hypermetropia, suffer from convergent strabismus? The answer is that the majority learn to dissociate to the necessary extent the actions of the accommodative and the converging functions. They manage to accommodate more than is normal without evoking excess in the movement of convergence.

A minority—the awkward squad as they may be termed—failed to do this, and these therefore squint. It is easy to understand that the functional adjustment of the nervous system, by which accommodative effort and convergence of the eyeballs are, in some measure divorced, is a somewhat delicate one, and that circumstances which tend to disturb the nervous balance may upset an arrangement which is in some senses an artificial one. Hence it is repeatedly found that squint appears after various illnesses such as pertussis, the specific fevers, &c., or after some accident or fright. The hypermetropia, by demanding excessive accommodation, is the underlying condition which establishes the tendency to undue convergence; the shock to the nervous system is the occasion that destroys the habit by which the patient has managed to use an excess of accommodation without an undue degree of convergence. Hence the appearance of convergent squint after circumstances involving nervous stress. Hence also an explanation of the fact that squint is a condition which comes on in early life, that is before the habits of the nervous system have become fixed. It appears most frequently between 3 and 4 years of age, but it may develop even during the first year of life. After 7 or 8 years it very rarely appears. By that time the hypermetropic child has so firmly acquired the practice of accommodating more actively than is normal without converging in excess, that no strain on his nervous apparatus disturbs the habit.

In connection with the treatment of squint the most important lesson for the profession, and through them for the public, is that “delays are dangerous.” A squinting eye depreciates, and the depreciation becomes more and more marked. The eye tends to lose the power of fixation, this being more especially true in those cases where the squint develops in very early life, and its capacity for visual purposes gets less and less. Even in those cases of alternate squint where the visual power of each eye remains good, delay may mean that after the eyes have been put straight binocular vision is impossible in consequence of the patient’s inability to fuse the retinal images. These are considerations which call imperatively for early treatment, and it is for the family practitioner to see that parents are made aware of the probable consequences of delay.

The first step in the treatment of every case of convergent strabismus is to estimate the refraction. If, as is the case in the great majority of instances, there is hypermetropia—even if this is not more than 2·0 or perhaps 1·5 diopters—it must be corrected by suitable glasses. There is no difficulty in teaching even the youngest child to wear spectacles. But something more is necessary. The defective eye must be educated. The best way to do this is to put a pad of wool inside the spectacles so as to cover up the good eye. This, more especially at the outset, will demand great patience on the part of the mother, but its value is great. Provided that treatment has not been too long delayed, it will be found that a squinting eye which has lost the power of fixation will regain this function. Even in a case where fixation has not been lost the covering up of the good eye is an advantage insomuch as the functional activity it develops in the weak eye leads to an increase in visual power. But these good results must not be anticipated if treatment has been delayed for years. Then, though it may be possible to cure the squint, restoration of function to the squinting eye may be entirely beyond the resources of art. In reference to operation the guiding principle is to cure the patient without this if possible. If, under the use of glasses and the discipline of education, the angle of the squint is found to be getting less and the visual power is improving, perseverance with these methods is to be advised; but if, after a fair trial, no improvement takes place, then operation is the proper treatment. This rule offers a definite principle for guidance, whereas the selection of a certain age, whether older or younger, is a purely arbitrary proceeding not founded on any principle or reason.

Mr. Priestley Smith illustrated his lecture by his well-known models of the nervo-muscular apparatus and refractive mechanisms of the eye-ball. Copies of these have been in possession of the Polyclinic since the classes were first opened, and members may consult them in the ophthalmological department.

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## SPRENGEL'S SHOULDER.

BY JONATHAN HUTCHINSON, F.R.S., LL.D.

GENTLEMEN,—The patient whom, through the courtesy of Dr. Travers Smith, I had the pleasure of bringing before you as an example of what we may suitably recognise as “Sprengel's Shoulder,” offered several points of interest which, in the hurry of the consultation, I was not able to discuss at the time. We will now, if you please, revert to it. I will first remind you of the salient features of the case and show you some photographs. Dr. Smith's patient is a well-grown girl of ten. It is seen at a glance that one shoulder—the right—is higher than the other, and when we examine closely we find that the scapula of this side is in all its dimensions smaller than that of the other. Its base is probably not less than an inch shorter, and the rest of the bone in proportion. The clavicle of the same side is nearly an inch shorter than its fellow, and is more slender. The scapula cannot easily be pushed down level with its fellow, and after this has been attempted it returns immediately to its place. All the muscles appear to be perfect, but the shoulder is obviously smaller as a whole than that of the opposite side. You will remember that I directed attention to the child's face, and I think the general verdict was that the right half of the face is smaller than the left. The want of symmetry is, however, not great, and we must not lay any stress upon it. When I state that the child has good use of the limb, and that in the forearm and hand the two extremities are alike, and add that the condition has been present from birth, I think we have completed the case. I have described a good typical example of “Sprengel's Shoulder.” So far as I know it is the first which has been recognised in England, and we owe our best thanks to Dr. Travers Smith for allowing us an opportunity of examining it. The diagnosis was his, and I am also indebted to him for references to some papers on the subject which I now propose to epitomise for your benefit.

It was in 1891 that Sprengel first drew attention to this malformation, and at that date he was able to describe four examples of it. The hypothesis which he suggested for its explanation was that owing to absence of amniotic fluid, the foetus in utero had been

fixed in a constrained position with the arm behind its back. It is not, however, easy to see how such an explanation would account for the non-symmetry of the face which Sprengel himself observed, and which others after him have also recorded.

A paper published by Pischinger, of which you will find an able



*Sprengel's shoulder in a young girl. (Dr. Travers Smith's patient.)*

and tolerably full abstract in *Pediatrics*, gives us a critical *résumé* of all the cases which at the date of 1897 its author could find on record. They amounted to seventeen (including those of Sprengel himself). The majority were on the left side. In almost all the scapula was simply raised in a vertical position and not displaced

obliquely. In almost all there was limitation in the extent to which the arm could be elevated, but at most it was not great. Other defects in development were observed in several cases, but only in a small minority. Thus, one had pes valgus in both sides, in another the radius was absent in one forearm, and on the opposite hand there was only a rudimentary thumb, in another one mamma was larger than the other, and one upper extremity was weak, and in a fourth there was an exostosis on one rib. In one of Sprengel's own cases, a sister of his patient had bilateral congenital luxation at the hip joints. In the journal from which I have quoted (*Pediatrics*) I find a record of a case observed by Dr. Virden, of New York, in 1897. Its subject was a girl of ten, whose parents had discovered a bony lump between the neck and the point of the shoulder. In her the left scapula was smaller than its fellow by three quarters of an inch in perpendicular measurement, and the clavicle was an inch shorter than its fellow. All the muscles of the left shoulder and upper arm were smaller than those of the right and the movements of the scapula and at the shoulder were somewhat limited. Nothing is said as to the symmetry of the face. In most respects this case is almost exactly like our own.

I must ask especial attention to one symptom which has been noted by most who have described cases, and which was well characterised in our own. At the time the girl was before us I asked you to examine the upper angle of the scapula and to note its apparent size and its hook-like projection forwards. This condition is a deceptive one. It has, in several instances, induced the surgeon to perform an excision, in the belief that an exostosis existed and that it had something to say to the abnormal position of the bone. In all it has been found that the projection was simply the angle of the misplaced bone. It need hardly be said that such operations are uncalled for. It is difficult indeed to see any indications whatever for interference of any kind in these cases. The condition is a congenital one of most obscure causation and productive fortunately of but little inconvenience. The fact that it is sometimes associated with other defects in limb-formation (absence of radius, &c.) and that a want of symmetry is often observed in the face would lead to grave doubts as to whether the hypothesis of malposition of the

extremity during intrauterine life, however at first plausible, is really adequate to explain all that we see. For the present, I think we must regard "Sprengel's Shoulder" as an addition—and one of great interest—to the large group of congenital defects which prove that it is possible for some influence (of the nature of which we know nothing) to interfere with bilateral symmetry in the development of the bones of the limbs and face. We know that it is quite possible for an entire bone, or almost the whole of it, to be omitted—a humerus or femur for example—and yet the distal parts of the limb to be of good size.

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*Pediatrics*, vol. vi. (1898), p. 285; vol. vii. (1899), p. 351; vol. ix. (1900), p. 386.

## DRIED FISH IN CENTRAL AFRICA.

THE "Route Journal" of P. J. Baptista<sup>1</sup> from Cazembe to Tette (1806) gives one or two important items of information. Of king Cazembe he says, "He is very black, a fine, stout, young man, with small beard and red eyes. He is well accustomed to white traders, who come to his court to buy and sell such articles as seed, manioc flour, maize, millet, haricot beans, 'canas,' and fish, which the people catch in the river near there called the Mouva." "There is a good deal of salt in that part which they get from the ground; there is also another kind of rock salt which is brought as a tribute from the salt district." Subsequently, "We crossed another river, called Bengeli, four fathoms wide. . . . we met two blacks loaded with dry fish, going to the large farm of the said Cazembe" (pages 188 and 189). The district here referred to is that just south of the southern end of lake Tanganyika and north of lake Bangweolo. We have here proof that the natives were accustomed to catch and to dry fish, and that it was an ordinary article of commerce in its dried state. We have also proof that they might, if so disposed, have salted it. It was near to this district that Livingstone, half a century later, met with a native leper (the king himself).

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<sup>1</sup> Translated by Captain Burton, and published by the Royal Geographical Society.

## NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

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### MEDICAL CASES.

BY DR. GUTHRIE RANKIN.

#### CASE III.—*Pernicious Anæmia.*

THIS man came under my care at the Dreadnought Hospital about three months ago, and was admitted complaining of faintness, shortness of breath, and general debility. We have only to look at him to be at once certain that he is suffering from some form of anæmia. His age, lemon-tinted skin, clear pearly sclerotics, impaired appetite, and fatness, at once suggest to all of us that the type of his anæmia is probably *pernicious*. I may tell you that his organs are all sound, his spleen is not enlarged, and the murmurs which are to be heard over his heart and large vessels are characteristically hæmic. He has never been seriously ill, and the onset of his present malady was insidious and without known cause. In the case of a man like this, who has lived a great part of his life in the tropics, such an anæmia should always raise the question as to the possibility of ankylostomiasis, but the fæces have been repeatedly examined, and no ankylostomal ova have been discovered. On admission it was found that he had several decaying stumps in both upper and lower jaws; but beyond an almost entire loss of appetite, he did not complain of symptoms directly referable to his gastro-intestinal tract. Now, the curious fact about this case is that the microscopical examination of his blood does not reveal the changes we would expect to find in a case of undoubted pernicious anæmia. There is marked poikilocytosis, a decided increase in the number of small lymphocytes, and the blood discs are notably diminished in number, and fail to form *rouleaux* in the normal way; but no nucleated red cells have been found, and the hæma-

globin is not relatively increased. I can suggest no explanation other than that the stage of the disease is not yet reached when those changes occur. The optic discs are very pale, and there are two small haemorrhages in the left retina, but the patient has had no bleedings otherwise. He has occasional temporary disturbances of temperature, but they are inconsiderable. Urobilin in pathological quantities has not, so far, been found in the urine. Since his admission he has not lost ground, but though he expresses himself as feeling better, I am unable, from my observation, to confirm his personal impressions. He is being treated with cacodylate of sodium, of which he now takes four grains a day, together with five grains of beta-naphthol night and morning. He is carefully and generously fed, and on alternate days has, as an addition to his ordinary diet, a few ounces of bone marrow and raw meat pulp.

#### CASE IV.—*Addison's Disease.*

Our next patient came to the out-patient room last Friday for the first time, and though I have not yet had sufficient opportunity of observation to have made up my mind definitely about her case, there is a great deal to warrant the provisional diagnosis of Addison's disease. It is fortuitous she should have turned up at the present time, because it affords us an excellent opportunity of comparing the discolouration of her skin with that of the man we have just been considering. You will see how different the conditions are: whereas the pernicious anaemia case has his skin uniformly tinted, as if from slight jaundice, this woman presents a distinctly bronzed appearance, and when we look at her carefully it is notable that the discolouration is due to a pigmentation which is not evenly distributed, but is in greater abundance at some situations than others. Round the areolæ, over the anterior folds of the axillæ, at the lower part of the abdomen and upper and inner aspects of the thighs, the discolouration is deeper than elsewhere, though the whole skin is abnormally dark in hue. On the lips, where skin and mucous membrane meet, there is also a distinct line of pigmentation. The patient came to the hospital on account of debility and attacks of faintness, which she ascribed to an intermittent diarrhoea from which she has suffered for about six months. She states that

lately she has lost flesh considerably, and that for many weeks she has had a troublesome cough and occasional night sweats. She has continual annoyance from a sense of weight and weariness across her loins, and this becomes at times so trying that she is obliged to lie down. The predominant symptom, however, is feebleness, which she declares is daily becoming more pronounced. She never feels warm, and when her temperature was taken last Friday afternoon it was found to be subnormal. On examination of her chest there is some evidence of disease in the upper lobe of her left lung: bronchial breathing; occasional moist râles of clicking quality, and comparative dulness on percussion. The sputum has not yet been examined, but there can be no reasonable doubt that the physical signs are due to chronic tubercular mischief. The local symptoms, however, are not enough to account for the excessive debility complained of, nor do they explain either the cuticular pigmentation or the gastro-intestinal disturbance. The whole circumstances point strongly to Addison's disease, and if it be so, the condition of the lung makes it likely that, in this case, the nature of the suprarenal degeneration is tubercular. The pathology of this disease is not clearly established, but degenerative changes of some kind are always found in the suprarenal capsules after death. Three theories are at present advanced in explanation of the symptoms :—

- (1) That the disorganisation of the suprarenal capsules deprives the economy of an internal secretion from these glands, which is requisite for perfect metabolism and for the maintenance of muscular and vascular tonicity.
- (2) That the function of the capsules is chiefly one of waste removal, and that their destruction allows of accumulation within the system of effete material inimical to perfect bodily health.
- (3) That the symptoms are due to secondary effects of the suprarenal disease upon the neighbouring semilunar ganglia and solar plexus of the sympathetic nervous system.

The initial treatment has been directed to the relief of the intestinal symptoms, and benefit has already accrued from the administration of large doses of Bismuth in combination with Salol.

She is coming into the hospital where she will be kept in bed, carefully fed, and put on suitable tonics together with suprarenal extract.

CASE V.—*Enlarged Spleen.*

My colleague, Dr. Hewlett, has kindly allowed me to bring this case that I may ask your opinion about it. The man was admitted to the Dreadnought some weeks ago complaining of pain in his right axillary region. On examination no physical explanation of the pain could be found, but it was ascertained that he had an enlarged spleen, and that his liver reached to about two inches below the costal arch. Neither organ was tender to pressure and otherwise he was apparently sound. He was unaware of any abnormal increase in his abdominal girth and considers himself, now that the right axillary pain has disappeared, perfectly well. He gives a frank history of occasional excessive indulgence in spirits, and says that he has never in his life been ill except from one or two very slight attacks of malaria.

His spleen is smooth to touch and is so large that, as you observe, its outlines are clearly visible. There is considerable distension of the superficial veins on the surface of his abdomen. He has no ascites and there are no murmurs over his cardiac area or in the large vessels of his neck. He has a ruddy complexion, is fully up to his normal weight, has never experienced any shortness of breath, and his blood is microscopically normal. The question is—what is the nature of his splenic enlargement? Can such a large spleen be explained by hepatic cirrhosis accentuated perhaps by his malarial attacks; or is the condition an early stage of leucocythaemia, or of splenic anaemia? It seems to me that none of the other known causes of splenic enlargement would, in any way, fit in with the symptoms.

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SURGICAL CASES.

BY MR. W. JOHNSON SMITH.

*Wednesday, June 19, 1901.*

CASE I.—A half-caste negro with elephantiasis, in an early stage, of the prepuce. A portion of the skin of the scrotum had previously been removed in Calcutta. At the same time living specimens of the filaria nocturna taken from this patient were shown.

CASE II.—A case of large inguinal hernia, with undescended testis on left side and marked atrophy of normally placed testis on right side. Patient aged 18 years.

CASE III.—A man aged 30, who, during convalescence after an operation for the radical cure of a large inguino-scrotal hernia on the left side, noticed a rapidly growing tumour in the middle of the anterior abdominal wall. The growth was diagnosed as a swelling of the omentum and as it was increasing rapidly in size and caused the patient much trouble, an exploratory laparotomy was performed. It was then found that the growth which involved both recti was extra-peritoneal, but its irregular and nodulated surface formed a distinct prominence in the abdominal cavity. On the administration of iodide of potassium in doses of from forty grains to one drachm, the growth speedily diminished in size, and when the man was shown at the Polyclinic only a small nodule could be felt. In this case there was an old history of urethral discharge, but there were no traces of ulceration on the external genitals, and the man according to his own report had not suffered from any general manifestations of syphilis.

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## DISEASES OF THE EYE.

BY E. TREACHER COLLINS.

*Friday, June 21, 1901.*

### CASE I.—*Horn of the Eyelid.*

A girl, aged 10, with a horny growth springing from the margin of the right upper lid. Its base was situated just above the line of insertion of the eyelashes, and measured about 2 mm. across. It was, when first seen, the same length as the eyelashes, and tapered a little towards its free extremity; during the last few weeks a portion of it had become broken off. It was probably formed by the accumulation and hardening of the epithelium on the surface of a small wart.

A specimen of a horn which was formed in this way and which was removed from the upper eyelid of a man, aged 72, was shown.

It measured 15 mm. in length, 11 mm. in breadth at the base, and 7 mm. in breadth at the apex. It was very hard, and of a brownish colour.

It was pointed out that in the removal of these growths the warts from which they originate must be cut away, as well as the cornified epithelium.

#### CASE II.—*Dendritic Keratitis.*

A man, aged 30, came complaining of inflammation and discomfort in his left eye during the last week. On examination a slight amount of ciliary injection was seen, and in the upper and outer part of the cornea was a gray patch with some irregularity of the surface over it. After some solution of fluoresceïn (fluorescine 2 parts, sodium bicarb. 3 parts, distilled water 100 parts) had been dropped into the eye, the gray patch became stained a brilliant green colour, and showed a very definite and pronounced shape. The patch seemed to have a central stem, out of which proceeded several buds and branches.

The form of corneal ulceration which presents this tree-like arrangement is always, as it was in this case, very superficial; it spreads by sending out fresh buds and branches, but does not extend deeply. The cause of it remains so far unknown, and there was nothing in the history of this patient to which it could be attributed. In all other respects he appeared perfectly healthy; he had never had malaria, which has been stated by some writers to be a constitutional condition which gives rise to the affection.

It was proposed to treat it by a vigorous application of absolute alcohol over the affected part—a procedure which, though it causes the patient for some hours afterwards considerable pain, is usually most efficacious.

*P.S.*—The absolute alcohol was applied three days after the consultation, but apparently not sufficiently thoroughly; for the affected area was not in any way diminished in extent, and the man had experienced but little pain afterwards. A second application was made four days later still, which caused him considerable pain, lasting for the rest of the day, and since which the ulceration has rapidly healed.

A week after the second application there was no staining whatever with fluorescine, very little injection, no photophobia or discomfort.

The amount of opacity left at the seat of the ulceration was comparatively slight, and likely to become less.

*CASE III.—Old Granular Ophthalmia with Extensive Pannus.*

A man, aged 24, who had suffered on and off from attacks of inflammation of his eyes since he was a boy at school. The present attack in his right eye had lasted for six months.

The entire surface of his right cornea was covered with blood-vessels, the ramifications of each of which could be distinctly differentiated, and which could be seen to be continuous with the vessels of the conjunctiva. There was no ulceration. The lids, on their inner surface, were very congested, and presented a velvety roughness, with some scarring ; but there were no definately granulations in them at the present time. There was a slight amount of non-purulent discharge.

The case was considered to be one eminently suited for treatment with jequity infusion. A freshly prepared infusion would be made by pouring a pint of water on a drachm of the powdered seeds, allowing it to stand, then decanting. This would be rubbed on to the inner surface of the lids four times in the course of an hour. A violent croupous inflammation would be set up, with considerable swelling of the lids, on the subsidence of which a disappearance of the blood-vessels and clearing of the cornea might be expected to ensue.

*CASE IV.—Neoplasm of Orbit, ? Gumma.*

A woman, aged 57, who first attended at the hospital on May 20 this year complaining of slight swelling of the lids of her right eye for the last three or four months, which had become much worse during the last week. She had no pain, only a sense of stiffness and discomfort about the eye.

On examination there was found to be marked œdema of the right upper lid, and some chemosis of the conjunctiva on the outer side. When she looked straight in front of her it was noticed that

the right eye was on a distinctly lower level than the left. There was some limitation in the movement of the right eye upwards.

On palpation, around the eye a sense of fulness could be detected beneath the upper border of the right orbit at the outer part. The finger could not be made to slide round the posterior edge of the upper border of the orbit as it did on the opposite side.

She was hypermetropic ; her vision with glasses, with each eye, was normal.

No definite changes could be detected ophthalmoscopically, but it was thought there might be a slight enlargement of the retinal veins on the right side.

There was evidently a growth of some sort in the orbit and the question to determine was whether it was inflammatory or malignant.

The patient was a married woman and had never been pregnant. There was no history of injury.

She had been prescribed iodide of potassium and had not been seen again until she attended at the consultation. In the meantime the symptoms had become less marked, the oedema was less as also was the displacement of the eyeball.

It was proposed to keep the patient under observation and to continue the iodide, gradually increasing the dose.

Had the symptoms become more pronounced instead of lessening in severity, an exploratory incision would have been advised.

*P.S.—July 11.* The patient has continued taking the iodide and there has been steady improvement. The fulness felt in the orbit is much less and the eyeball moves freely upwards.

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## CASES WITH COMMENTS FROM THE SURGICAL CLINIC.

BY MR. HUTCHINSON.

*Graves's Disease associated with Leucoderma. Question as to the Symptom-Significance of the latter.*

(Dr. Harry Campbell's case.)

THE patient in this case was a man of about 35, so emaciated as to be little better than a living skeleton. Dr. Campbell told us that he had been under his treatment for epilepsy, and had subsequently developed all the usual symptoms of Graves's disease. The questions which he wished to submit for discussion, however, related, not so much to the latter malady as to the state of the man's skin. On the latter there had appeared, it was believed quite recently, white patches attended by a general deepening of tint on the rest of the surface. The man being stripped, we found on the sides of his neck and shoulders large areas which were quite white, and which presented abrupt borders. By coalescence of these the whole of the shoulder region had been bleached. Similar patches, but smaller in size and most of them nearly round, were present on the lower part of the abdomen, and the patient drew our attention to a few yet smaller ones on his hands, which were so indistinct that they might easily have been overlooked. On all affected parts the white patches were arranged with very exact bilateral symmetry. In discussing the case I remarked that it presented a typical example of Graves's disease with great failure of health, and also a good illustration of the condition known as leucoderma. Was there, or was there not, any real connection between the two? I inclined to the belief that we could not assume that there was any. Leucoderma was a not uncommon affection, and it was quite certain that it often—indeed, usually—occurred to persons in perfectly good health. Not unfrequently, however, it was met with in association with some form of cachexia, and then, as in the present instance, suspicions were often entertained as to its being a part of the general malady. It might be the fact that in some of these cases it is discovered simply because the patient, being ill, has his clothes removed

for examination, and thus the white patches, which may have been there for long, are brought under an observant eye and taken note of. Many a man is the subject of leucoderma and never shows his patches to any doctor. They cause him no inconvenience, and he takes no trouble about them. So far as my knowledge goes, I can attach no significance whatever to a create leucoderma as a symptom. Very commonly, when we are consulted about it, it is from a belief on the patient's part that he is getting brown, not that he is getting white ; and this belief on his part it is usually very difficult to overcome. In the case before us, and in many others, the question is whether both processes do not exist together ; whether, indeed, a general diffuse pigmentation has not preceded the bleaching. The contrast between the white areas and the brown ground in which they are placed is so marked that it becomes very difficult to escape the impression that the brown is not too brown for any normal condition. I feel certain that this impression is usually an error. As in so many other affairs of life, we base our impressions on strong contrasts, and by so doing are led astray as to realities. In Dr. Campbell's patient, who is, as you see, of a rather fair complexion, the skin generally is rather muddy ; my first thought was, indeed, that he had been taking arsenic, and such, indeed, we are told is the fact, though not over any very long period. He is not, however, very brown, and his hands, indeed, are so pale that we can scarcely be sure of the leucodermic patches. On his neck the contrast is not very great. It is on the lower part of the abdomen that darkness of tint is most suspicious. We must remember that the skin of the penis and of the pubic and lower abdominal regions is in most persons of deeper tint than most other parts. It is on the penis in fact, that leucoderma is most frequently seen, not perhaps because it is more common there, but because it is more conspicuous than on other parts.

Thus, then, to sum up, I am inclined to say that I think that when symmetrical patches of leucoderma are observed in those who are suffering from constitutional disease, they should be regarded merely as accidental concomitants. It is, however, always of importance to estimate the evidence as to darkening of the skin, which is a symptom which attends many forms of cachexia. It may be that a general deepening of tint, due to Addison's malady, to arsenic,

or to some other cause, has brought out into notice white patches which had been previously unobserved. This may have been the case in Dr. Campbell's patient.<sup>1</sup>

*Scirrhous Tumour in One Mamma Thirty Years after Excision of a similar Growth from the other.*

The following are the particulars of this case. Mrs. S., was sent to me by Dr. Robert Barnes in 1870 for a scirrhous growth in the inner and upper part of the right breast. It was quite isolated and in the extreme periphery of the gland. I excised it at her own home (December 10, 1870), Dr. Garman, of Bow Road, taking charge of her afterwards. I did not remove the whole mamma, nor even the nipple, but took away freely about a third of the gland in which the tumour, as big, perhaps, as a half walnut, was embedded. The wound healed without suppuration. Mrs. S. was then 34 years of age. She told me that her mother had died of cancer of the womb under the late Dr. Ramsbotham sixteen years after her last confinement (the birth of my patient). A maternal aunt had also died of "cancer of glands," being "a perfect skeleton," and "with growths all over her."

Thirty years elapsed before I saw this patient again.

In July, 1901, Mrs. S., was again sent to me. She now had a tumour in the outer part of the other breast of stony hardness and involving the skin. She had known of it for about ten months and said that it was growing fast. There were some hard glands in the armpit. Mrs. S. was florid and in excellent health, and on the side on which the excision had been performed all was perfectly sound. Her age was now 64. She had, in the interval, borne one child which had died of whooping cough. Mrs. S. attended at the Polyclinic on July 5, when her condition was demonstrated to those present, and her history detailed. She was subsequently admitted into the London Hospital under my son's care, by whom the left mamma and axillary glands were removed. Both the tumour and glands presented characteristic conditions.

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<sup>1</sup> Many will remember that Sir W. Gairdner, in his interesting lecture, reported in vol. i., mentioned a similar case of leucoderma with cachexia.

Having regard to the history of the patient's relatives as well as to her own, we can have little doubt that there existed a tissue-proclivity to cancerous growth. Yet, as is probably usually the case, this tendency was not of great strength. It had to wait until, perhaps, some slight blow or other local injury, serving as an exciting cause, enabled it to manifest its force. That the local area involved was in the early stage, only small, is proved by the fact that through thirty years no recurrence took place. The implication of the other breast after this long interval must be held to have been quite independent of the first growth. The two had no connection other than they both were in a slight but definite degree due to tissue-proclivity. Of course I do not defend the practice which was adopted of removing only a part of the breast, it is far safer to excise the whole and such for many years has been my almost invariable practice. I should not be surprised if this case was the last in which I ever deviated from it. Having regard, however, to the fact of non-return we may claim the partial excision as giving additional force to the arguments as to the strictly limited location of cancer in its early stages.

*Tubercular Disease of the Testis, presenting unusual Conditions.  
(Mr. Roland Smith's case.)*

The subject of this case was a thin pale man, aged 28, engaged as a clerk in a City office. Both his parents were living, and he had a grandmother aged 92. In spite of this good family record he became, however, at the age of 18, the subject of chest delicacy, and was sent to Australia for his health. He returned recruited, and enjoyed good health afterwards, being free from cough. He was brought to me on March 5, with his right testis swollen to the size of a man's fist, and glued to the skin. It was not painful, and he complained chiefly of sense of weight. His statement was positive that it was only a month since the first symptom. What first occurred was a rather sharp pain, which lasted only ten minutes, and did not return until four days later, when swelling set in. It was a question of diagnosis between a malignant growth and inflammatory disease. I inclined to the latter, and advised an incision into a part which seemed to fluctuate.

This was done at his home by Mr. Roland Smith, under whose care he was, and who reported to me that he had removed pus from the tunica vaginalis, and had incised the testis itself, which was much enlarged. A month later I urged excision of the gland, as treatment by small doses of mercury and quinine had effected nothing. He was admitted under the care of my son into the London Hospital, and the testis was removed. The gland was enlarged to the size of an egg, and was infiltrated in all parts of both testis and epididymis with tuberculosis deposit. There were no isolated masses. The tunica vaginalis had been the seat of suppuration. The case is of interest as an example of rapid but almost painless enlargement being the early stage of tubercular disease, and by the speedy sequel of empyema of the tunica vaginalis. We may also note with interest that the man had recovered from pulmonary tuberculosis ten years before his testis was attacked.

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#### OUR CLINICAL WORK: A RECAPITULATION.

The summer vacation,—to be followed immediately by a new session of work,—seems to offer a good opportunity for a brief recapitulatory notice of what has been done in the past year. In attempting this we shall not aim at anything approaching completeness, which would become tedious. We shall select for notice only a few of the more salient topics which have engaged our attention, and especially those to which more or less of novelty may appear to be attached. It has been repeatedly pointed out that in one, perhaps the chief department of our usefulness, the Polyclinic resembles a Medical Society for the investigation and record of clinical facts. In this capacity, and by affording to all our members the freest possible opportunities for the production of examples of exceptional forms of disease, our Institution has been the means of preventing the loss of a large amount of invaluable clinical material. The retrospective review of this, which we now propose, will it is hoped not only serve the purpose of justifying our arrangements by proving their success, but will also make them yet more useful. We shall endeavour to some-

what group the facts which have been observed, and thus to bring into juxtaposition cases which have come under notice on different occasions. We shall also, in many cases, be able to supply additional particulars. Most of the cases which we shall mention have already been recorded, more or less at length, in our pages, but we shall not scruple to refer to others which for one reason or another have escaped publication ; nor, although professing to deal chiefly with the last twelve months, shall we feel restricted from mentioning some which came before us in the preceding year.

#### *Tuberculosis.*

Tuberculosis in all its various forms has received unremitting attention in the various departments of our work. Clinical lectures and demonstrations of cases have been given by our President, Sir William Broadbent, by Dr. Theodore Williams, Dr. Edward Squire, Dr. Bowles, Dr. Rankin, and others. Many of the patients brought forward afforded very interesting opportunities for observation at the time, but for obvious reasons this class of case, although the most important of all as regards diagnostic and therapeutic education do not offer much material for special record. Still less is it practicable to offer any useful condensation of those facts which have been given in our pages. For this reason, and for this only, we must on the present occasion leave the greater part of our specially medical demonstrations aside.

Dr. Burney Yeo discussed the treatment of tubercular peritonitis in a clinical lecture delivered in December, 1899. Dr. Arthur Newsholme, Medical Officer of Health for Brighton, dealt with the prevention of phthisis in a very interesting lecture given on January 23, and some "Tuberculosis Problems" were set forth in a leader of February 1, "Miliary Tuberculosis of the Skin" has also been discussed in a leader,<sup>1</sup> and examples of it described in the catalogue of the Museum. In vol. ii., at page 236, will be found some important remarks by Dr. Theodore Williams on the recumbent position in the open air treatment of phthisis.

#### *Congenital Dislocation of Hip Joints.*

One very characteristic example of this condition has been before us and photographs have been preserved. As the patient, a girl of

<sup>1</sup> See vol. iv., p. 167.

10, could run, dance and play as well as others, her mother was advised not to submit her to any operation.

### *Finsen's Light Treatment of Lupus.*

The cure of a lupus patch by Finsen's light rays was illustrated by a case produced by Mr. Malcolm Morris at a clinical lecture on January 21. Mr. Morris has also on two occasions kindly invited our members to visit his private establishment for this treatment and has then demonstrated many interesting facts.

Two cases in which this treatment had been employed elsewhere have found their way to our clinic. In one of these, an example of extensive lupus vulgaris of the face, we were told that 179 applications had been made, and it looked as if at least twice as many more would be needed before anything approaching a cure could be announced. In another a patch of lupus vulgaris on the knee of a young man had been treated without benefit. After a few applications the treatment was abandoned in consequence of an abscess which had formed under the adjacent skin. After the abscess had healed numerous satellite patches of a lupoid character developed above and below the knee. It was for this remarkable extension of the disease that the patient sought our advice. The original lupus remained much as it had been for years but was slowly extending at its borders. A good portrait by Burgess, showing the present condition of this patient, has been preserved for the Museum, and can be inspected at any time.

### *Therapeutics, Drugs and Diet.*

The uses of Urotropine were the subject of special communications from Mr. Reginald Harrison and Mr. Buckston Browne in vol. iv., pages 91 *et seq.*

Dr. Ewart dealt at some length with the virtues of the Cacodylates in some clinical remarks which will be found at page 157, vol. iii., and slow Arsenical poisoning was the subject of a leader at page 6 of vol. iv. This was suggested by the Lancashire epidemic of beer poisoning, to which references have repeatedly been made. By the kindness of Dr. Kelynack, of Manchester, two good original drawings illustrating the discolouration of the skin from arsenical

beer have been added to the Museum. Some additional items as to arsenic will be found at page 121, vol. iv. The use of gelatine injections in the treatment of aneurism was discussed by Dr. Guthrie Rankin in a clinical lecture and illustrated by two cases.

Cases of phthisis illustrating treatment by Maguire's intravenous formaldehyde injections were demonstrated by Dr. Ewart on February 12.

In a case of Raynaud's phenomena in a severe form in a woman, the value of small doses of opium, long continued, was well shewn.

### *Spondylitis Deformans.*

Several examples of this exceptional form of rheumatic arthritis have been investigated. In one very remarkable case (Mr. Deas) the patient, had had a number of abscesses near to joints, with exfoliation of small fragments of bone.<sup>1</sup>

### *Charcot's Joint Disease.*

We have had before us at least two good cases of the extensively disorganising but comparatively painless form of arthritis which occasionally occurs in the subjects of tabetic ataxy. In one case, in a woman, one knee was affected in association with eye symptoms, &c., which made the diagnosis of remote syphilis very probable, but in another very similar one of which a farm labourer was the subject no evidence in support of such an opinion could be obtained.

### *Recovery from Landry's Paralysis.*

A very instructive example of recovery from a severe attack of Landry's paralysis had its value much increased by the circumstance that a good narrative of the early symptoms was forthcoming. The patient, a middle aged man, had regained perfect use of all his limbs, but his facial muscles still remained weak, two months after the illness. The case-narrative showed that these had been the latest implicated, so that the order of recovery had reversed what is reputed to be usual. For a time all the four limbs had been completely paralysed, and although sensation was not lost it was dull.

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<sup>1</sup> See vol. iv. p. 93.

As usual the sphincters had escaped, but for a time there was difficulty in swallowing, and some embarrassment of respiration. The recovery took place under mercury, rapidly pushed to salivation. Although syphilis was suspected there was much reason to doubt whether the man had ever had it. He had appeared to be in good health until within a fortnight of his illness.

*Pulmonary Osteo-Arthritis. "Marie's Malady."*

An exaggerated example of the condition which simulates acromegaly, but is in connection with chronic chest disease, was sent to us from one of the workhouse infirmaries. The patient, a man of near 50, was the subject of chronic phthisis in an advanced stage. His hands, their digits especially, were much enlarged, and might have been taken for those of marked acromegaly were it not that the ends of the fingers were clubbed, and that their nails were expanded. The man's chest was very narrow, and he could not straighten his back, but sat bent forwards to such an extent as to make auscultation from the front difficult.

*Large Gummata of the Liver.<sup>1</sup>*

The case of a young man who had tumours in his liver, so large that they produced visible projections, was of exceptional value in reference to diagnosis. They had been suspected to be hydatid. The lad's aspect showed nothing suspicious, his teeth were good, and he was well grown. A peculiarity in his speech led to inspection of his throat, and it was then found that his soft palate had been extensively destroyed. Finally, the diagnosis of inherited syphilis was well established, and the large gummata in his liver subsequently melted away under full doses of iodides.

*Destruction of Soft Palate in Inherited Syphilis.*

In several cases in which the recognition of inherited taint in young adults was in question, the discovery that the soft palate was partially destroyed and tied-up by adhesions to the walls of the pharynx has proved very valuable. In some of these but little

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<sup>1</sup> See vol. ii., p. 288.

other evidence could at first be discovered, the teeth being free from defect and the physiognomy good. In one of these cases in which this symptom was specially helpful, a young woman who was well grown and of good features had a deep ulceration in her tongue, which looked like a gumma. She had also the sabre-shaped tibiae of bygone osteitis. The family history was so absolutely negative that although the cure of the tongue by iodides convinced all that she was the subject of syphilis, there remained much doubt as to whether it was acquired or inherited. Finally, however, an attack of keratitis removed this doubt, and the case therefore stands as an instance of what is by no means common, a sloughing gumma of the tongue, consequent upon inherited taint.

#### *Diagnosis of Inherited Syphilis.*

We have had many opportunities for appreciating the difficulties which often attend the diagnosis of inherited syphilis in infants, and the most remarkable manner in which the parental history may not only be absent, but may seem to bear strongly in the negative direction. In one of these an infant had multiple epiphysitis and snuffles, but its mother was healthy, had other healthy children, and could not give the slightest clue to any ailment of a suspicious nature in either herself or husband. The same facts were repeated in another case in which the infant was covered by a most characteristic eruption.

#### *Syphilis in the Third Generation.*

A very narrow escape from a mistaken recognition of syphilis in the third generation occurred in the case of a married woman who brought a syphilitic infant, and who was at once recognised as bearing in her own physiognomy and teeth unquestionable evidences of inherited taint. At first all history of acquired disease was denied, but finally the woman admitted that soon after her marriage she had been under hospital treatment for sores on her genitals. We have had no other case in which third-generation inheritance has even come into question.<sup>1</sup>

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<sup>1</sup> Vol. ii., p. 40.

*Sycosis-Keloid of the Nape.*

A series of valuable cases illustrating this peculiar, and for the most part, local disease, have come before us and several drawings have been preserved. It is one with which the name of Morrant Baker may be very suitably associated. One of our patients (presented by Mr. Hitchins) showed the condition, not on the nape only, but spreading as a sycosis over a large area of the hairy scalp. Another well illustrated the fact that, like keloid of scar, the dense masses present in this disease are susceptible of spontaneous involution and may disappear leaving apparently sound, but hairless, skin. The disease was aggressive at its upper border but had left a large sound area below. In a third case an important feature was that the keloid of the nape was coincident with a sort of acne-sycosis affecting the hair follicles over the whole back. This case is especially valuable as supporting the conclusion which all the others had been held to illustrate—that the primary lesion is one, not of papillæ, but of the hair follicle and its adjuncts. The most careful attention has in each instance been given to this point.

The explanation which has been offered of the peculiarities of the malady is that it begins as indurated sycosis-papules around hair follicles which rarely suppurate but are very pruriginous. The nape of the neck is a part easily, and at all times, accessible to the finger nails, and the subject of these papules readily acquires the habit of scratching and picking them. Under the influence of this species of traumatism the keloid develops, and once begun it tends to progress. In several instances the patients have themselves fully admitted the adequacy of this hypothesis. In one case an amusing conflict of evidence took place. The man denied that he had been in the habit of scratching his nape, but his wife intervened, "Why, John, you are always doing it. I have begged you not to a hundred times." Whilst asserting that the large majority of cases of this kind conform to the type illustrated by the cases mentioned, and that the disease has in them no claim whatever to such an epithet as "papillaris," it is not denied that in others the same class of causes may provoke papillary outgrowth. We have drawings in the Museum which appear to illustrate this, but no example of it has been presented in our clinic.

There is a form of chronic eczema attended by a patch of hardened skin in this region which is not by any means uncommon, especially in women, but which does not pass on to actual keloid. In the production of its peculiarities the finger nails take a large share, but it is generally coincident with eczema in other parts. Of this condition several examples have been demonstrated in our theatre.

*Yaws and Syphilis.*

The question of the identity of the disease known as "Yaws" with Syphilis has been illustrated by two remarkable cases. In one of them a man presented himself who had contracted yaws from a primary sore on his forearm, in West Africa; he had passed through the ordinary secondary eruption, which had been recognised as yaws by several good authorities on the spot. He came to us eighteen months from the onset still covered with a polymorphous eruption on his limbs, and with peeling patches in palms and soles. No one who saw him doubted that he was now suffering from syphilis, and when subsequently he was presented at a meeting of the Tropical Section of the British Medical Association an unanimous vote to this effect was taken. Portraits have been preserved in the Museum, and with them those of another exactly parallel case, the subject of which could not be produced at our Demonstration. In this second one the date of the inoculation was known, and also that it was from a yaws sore. Both cases were cured by mercury, &c. In another case the converse proposition was demonstrated; its subject was a young woman in whom the secondary eruption of unquestionable syphilis presented the framboesial type. Her face was covered with fungating granulomata. Dr. Finucane, an observer familiar with so-called "yaws" as seen in Fiji, was present at the demonstration and agreed that the eruption displayed was in all respects exactly that of "yaws."

*Molluscum Contagiosum produced by Heat.<sup>1</sup>*

In respect to its pathological bearings one of the most novel of our observations concerns the influence of heat in producing

<sup>1</sup> See vol. iii., p. 40.

molluscum contagiosum. A child whose arm had been sharply scalded, but without causing sloughing of skin, had a crop of little molluscum buttons over the middle of the area to which the heat had been applied. It has long been asserted that the use of the Turkish bath is a fertile cause of molluscum. The original drawings, which illustrate the first cases in which this was observed, are in our Museum. Now, although probably most London authorities have seen reason to recognise this fact, in no case has any source of contagion at the bath been traced. Our new fact would suggest that it is possible for heat alone to excite to activity the adenoid growths which characterise this malady. If further experience should confirm this conclusion we shall have a most interesting proof that it is possible for a physical influence to bring into being a form of growth which is unquestionably accompanied by living elements which enable it to spread as a contagious disease.

*Local Lipomatosis, Congenital Lipomatosis and Acute Lipomatosis Universalis.*

The various forms of lipomatosis—using that term as inclusive of all forms of excessive formation of fat—have been well illustrated. An advanced example of the diffuse lipoma of beer drinkers occurs in a man who resides near to the Polyclinic, and can be produced at any time. This form is met with only in men, and the nape and neck are the parts usually affected, although it may sometimes occur in the pubic region, as photographs in the Museum show.

A remarkable example of multiple lipomata of enormous size and symmetrically placed was brought before us in the person of an elderly Jewish woman. The neck, the shoulders and the abdomen were the parts chiefly affected, but although the growths were symmetrical they did not in the least simulate the arrangement of those just referred to, and many, if not all, appeared to be encapsulated. The woman was naturally obese.

In one of Dr. Payne's demonstrations an interesting example of congenital obesity was produced.<sup>1</sup> The patient, a woman of 22,

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<sup>1</sup> See vol. ii., 223.

weighed more than twenty-one stones. Menstruation had been regular and the health good.

The most important of the cases in this group was that of a young woman who attended for consultation in November, 1899.<sup>1</sup> She was an example of the almost acute form of lipomatosis universalis. Rather suddenly the tendency to fatten had set in, and at the same time menstruation had been suspended and the bodily strength had failed. She was very weak, enormously fat, and seamed all over with florid, sub-epidermic scars, some of them an inch or two broad. These red scars—all of them recent and of almost simultaneous development—presented a most remarkable appearance. We have in the Museum a drawing (taken from an American source) which represents the exact condition which our patient displayed. It is the only one with which we are acquainted illustrating this condition, and unfortunately it is not well executed. It may, however, serve well as a map, and as an indication of the extent to which the condition may be carried.

We are able to report the progress of our patient up to the present date. So great was her debility for some time that it was feared that she would die. At length, however, the tendency to accumulate fat appeared to cease, and her health improved. Menstruation has been restored, and she is now, although very stout, able to enjoy life. It is possible that the use of ovarian extract was the turning point in the malady, but it has not been continued.

#### *Elephantiasis and Elephantoid Edema.*

A very interesting lecture was delivered on May 5, by Colonel Kenneth McLeod, dealing with elephantiasis as met with in the tropics. At this lecture Sir Joseph Fayrer took the chair, and contributed some remarks.

Dr. Manson produced at one of our consultations a patient from the tropics, illustrating in a most interesting manner the enlargement of the lymphatic trunks in the groin which often attends, and sometimes precedes, elephantiasis, and is consequent on the presence of the filaria.

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<sup>1</sup> See vol. i., p. 60.

A number of cases have from time to time attended in our Clinical Theatre illustrating various stages and degrees of elephantoid hypertrophy as observed in those who have never left England. In almost all these, as might have been expected, the lower extremities, one or both, have been the parts involved. In the majority the doctrine that the condition takes its origin in some slight traumatism, followed by recurring attacks of dermatitis not easily distinguished from erysipelas, has been borne out. It has been pointed out repeatedly that these cases in England present exactly the same features, and may now and then proceed to just as great hypertrophic growth as do the tropical cases. The chief difference is that they are common in the tropics and rare in England. In England, and possibly in a large proportion of the tropical cases, there is no proof of the presence of any parasite.

*(To be concluded.)*

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#### REVIEWS AND NOTICES OF BOOKS.

A TEXT-BOOK OF MEDICINE. Edited by G. A. Gibson, M.D., Physician to the Royal Infirmary, Edinburgh. Two volumes, pp. 824 and 909. Young Pentland.

WE have here two large volumes of closely but clearly printed matter, accompanied by an excellent index. The work is not written by the distinguished Edinburgh physician whose name it bears, but only edited by him. Nor were Dr. Gibson's collaborateurs by any means exclusively Scotch. His list contains thirty-six names, almost all of them those of men holding foremost positions as authorities on the subjects upon which they have been asked to write; and of these less than a third reside north of the border. It may be admitted that were we to count by place of birth, the proportions might probably be greater.

Dr. Gibson has been fortunate in those whom he has enlisted, and judicious is his allocation of subjects. The result is a text-book of medicine well up to date, and of the utmost value alike to the student and the practitioner. As is inevitable in a work which

is the product of many pens, the chapters are of somewhat varying merit, but this criticism concerns chiefly their length and the amount of detail given, for all are of high quality. It might be of interest to compare this work with Watson's Lectures, and to attempt to measure, in so doing, the progress which medical knowledge has made in a half-century. But perhaps a better standard for comparison would be Copland's Dictionary. The progress has, however, been such that we shall perhaps never again see either a Watson or a Copland. On all hands the subject matter has become too vast and too full of detail to be satisfactorily undertaken by one man. The work before us does not compare with Watson's Lectures, nor indeed with those of Rousseau, nor with the admirable treatises of Dr. Hilton Fagge and Professor Osler, in its attractiveness to the reader. It is, as its title implies, a text-book, and is designed mainly for class-room use. It is, at the same time, exceedingly well adapted for a work of constant reference on the consulting-room table.

Our space does not permit of our attempting any criticism or analysis of special articles. We have read with great pleasure those by Dr. Hector Mackenzie on Tuberculosis and on Syphilis. Nearly all those on Tropical Medicine and that on Malaria are from Dr. Patrick Manson's pen, and it is needless to praise them. Sir William Gowers, Dr. James Taylor, Dr. Mott, and Dr. Risien Russell contribute the principal chapters on Diseases of the Nervous System. "Diseases of the Kidney" is written by Dr. Rose Bradford, and is excellent. Under the heading, "Integumentary System," Dr. Allan Jameson gives us an admirable treatise of more than a hundred pages on what are vulgarly called "Diseases of the Skin." From a sentence in his preface we learn that the Editor admitted this chapter with some compunction. He appears to think that these diseases constitute a speciality, to be comprehended and taught only by specialists. We must protest that there can be no greater mistake. The details of the pathology of the skin can be as easily acquired by the general physician, if he will give attention to them, as those of the lungs or of the kidneys; and they are in no doubtful sense fundamental to the rest of medicine. Above all, it is necessary to the students and practitioners for whom this book is written, that they should understand dermatology. It would have

been treason to the progress of medicine to have omitted them from such a text-book as this. The great majority of so-called "skin diseases" are symptoms—and often very important ones—of constitutional states.

With one remark in Dr. Gibson's short preface we most entirely concur. He writes:—"Certain symptoms occasionally dignified by the title of separate diseases, will be sought in vain under individual headings, but will be found as parts of the subjects to which they properly belong." This is as it should be and there are not a few of what still stand as names for substantive diseases which might be so relegated, greatly to the relief of the student.

AN INDEX OF SYMPTOMS AS A CLUE TO DIAGNOSIS. By R. W. Leftwich, M.D. Second edition. Smith, Elder & Co. Pp. 267. Price 6s. 3d.

"Lest we forget" might be taken as the motto for Dr. Leftwich's little work. It is a book of reminders. The practitioner who has it in his carriage can at any moment turn up the name of any symptom which he may have observed in the patient whom he has just left, and find a list of the diseases which it may possibly denote. Take, for instance, "*Pigmented or Bronzed Patches;*" beginning with Addison's disease and ending with Urticaria pigmentosa, he will find a list of nineteen different conditions of ill-health which such patches may attend. He will, however, not find anything more. The work does not profess to guide us in diagnosis, but merely to remind us of things which we might otherwise have failed to recollect. As such it is likely to serve a very useful purpose, and the publication of a second edition proves that it has been already found acceptable. The division of the work into different parts strikes us as somewhat arbitrary, and might perhaps with advantage be abandoned. For instance, we find all that concerns the pulse placed in a chapter on "Palpation." Part I., "concerns symptoms elicited by Interrogation," and Part II., "Inspection and Observation." Yet the first begins with Achondroplasia and continues with Icterus, Nævi, Syphilis, &c.; whilst the second has "Menopause" and "Cessation of Active Occupation." A reversal of the position of these topics would have seemed reason-

# THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES'  
COLLEGE, LONDON.

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VOL. V., No. 4.—OCTOBER, 1901.

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## OUR FINANCES.

OUR members will have observed that in our recent numbers forms for application for membership, for subscription to the Journal, and for donations and bequests to the funds of the Institution, have been interleaved. Some may have thought that in the case of those who have already joined us these are superfluous. In reality they are not so. It is most desirable that all who take interest in the POLYCLINIC, and especially those who profit by the advantages which it offers, should be reminded, from time to time, of the need that there is for all to exert themselves to increase our members' list, and in other directions to aid our finances. The very best way of attaining this latter object is to enlist new members, since it not only adds their subscriptions to our income but extends our usefulness as a clinical school. Donations of money will, however, also be very acceptable to our Treasurer, for we are in great need of it.

It must be obvious to all that the annual subscription of a single guinea is, in relation to what is offered, little more than nominal. In the like spirit the fees for our courses of lectures have been reduced to a minimum. It has been the desire of the Council to make our consultations and our class rooms accessible to as many as possible; and that none should be excluded by want of funds. Had our annual subscription been five guineas, instead of one, it would not have been unreasonable, since it secures the Journal and admits to the Library

and Museum and to Consultations five days a week during a whole year. The principle upon which the Council has acted in keeping the subscription fee so low is, we believe, a sound one, and may be considered to be likely, on the whole, to work well. It has, nevertheless, been the means of keeping our income small, and it makes it perfectly legitimate that we should remind those of our members who can afford more that they ought not to consider their obligations discharged by the bare payment of the annual subscription.

We are engaged in a great work for the advancement of medical knowledge, and we make no hesitation in urging a strong claim on the liberality of those who understand our aims.

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### CLINICAL EXCURSIONS.

THE visit paid by some of our members on Saturday last to the Surrey County Hospital, and other hospitals in this far corner of Surrey, although not organised under the auspices of the Council had the sanction of some of its leading members. It was in some respects an experiment, and as such it may, we feel sure, be regarded as having been a success. Those who took part in it spent a very pleasant day, and one affording excellent opportunities for the development of clinical knowledge. It is part of the vocation of the POLYCLINIC to endeavour to make use of materials hitherto somewhat neglected, and in doing this it may suitably not content itself with inviting the attendance of instructive patients at its consultations, but may also go out in search of them. It is surely a matter of regret that the wards of a large and admirably-managed County Hospital such as that at Guildford, should not take a larger share than is now the case in the cause of medical education and the advancement of our art. They are in all respects excellently fitted, both as regards the patients and those who have charge of them, to furnish opportunities for post-graduate teaching and clinical discussion. Nor are smaller institutions, such as workhouse infirmaries and cottage hospitals, to be neglected. It is there, not unfrequently, that the clinicist may find his most valuable facts. Apart from these considerations, we may also urge that visits of the kind referred to, are likely to be useful in giving us familiarity,

on a wider basis, with the possible causes of disease. As will be seen by what we record at page 194 *et seq.*, some attempt was made to estimate the prevalence of different forms of disease in the districts visited, and to take into consideration climatic and geological conditions as possible factors in the result. Nor were the items of evidence thus obtained, although it is to be admitted somewhat fragmentary and inconclusive, without their value. They need of course to be corroborated or modified by further research. This research must, however, be on the same lines, and we are very hopeful that the excursion to Guildford may prove the beginning of an important work, and add a new and very valuable department to those in which the POLYCLINIC is already engaged. For the present it will probably be best to restrict our visits to the immediate neighbourhood of the Metropolis. The Margate Infirmary, and those of Reading, Aylesbury, Ipswich, Winchester, Brighton, Maidstone, and Canterbury, might all furnish very attractive centres and could each be easily visited in a single day's excursion.

It is desirable also that an excellent suggestion made by our Dean in one of his recent Notes should not be lost sight of. It was that summer excursions to British Health Resorts should be organised. These should extend over longer periods, and would be in some sense complementary to the shorter ones now proposed. Both would have the collateral advantage of bringing medical men into mutual association and facilitating that interchange of opinion and experience which is so valuable in promoting practical knowledge.

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#### BRONCHOCELE EPIDEMICS.

INSTANCES of the epidemic prevalence of bronchocele have occurred repeatedly on the Continent, more especially in France,<sup>1</sup> but we are not aware that any such have been recorded in the British Isles. The mention of one which we make at p. 201 is therefore of especial interest. No authorised account has, we believe, been yet published, and our knowledge of it is derived from private sources. It is said that at one time in the King Edward's

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<sup>1</sup> Dr. StClair Thomson has informed us that, to his knowledge, several epidemics of bronchocele have occurred in different schools in the town of Lausanne.

School at Witley at least a third of the scholars were the subjects of enlargement of the thyroid gland. It might seem that such outbreaks would afford good opportunities for study of the cause of the malady and for removal of some of the mystery which surrounds it. In this instance, however, we believe that no increment of knowledge has resulted. The epidemic began in a school which had been established in the same premises for many years and without any known alteration in water supply, food, or other hygienic conditions. It subsided also without any known influence on its decline. The form of goitre which occurs in these instances is always that known as parenchymatous or hyperplastic, and consists in a general enlargement or fulness of the whole gland. The best account of these epidemics will be found in that wonderful store-house of facts, "Hirsch's Handbook of Geographical and Historical Pathology." In most instances garrisons of young soldiers were their subjects, but in several they were the inmates of schools, and in some the sojourners in a boarding-house. Repeatedly it has been observed that the same place was the site of successive epidemics with intervals of several years. For the most part the disease was restricted in its occurrence to one establishment and to the younger of the residents in it. Almost always the locality has been one in which goitre was known to occur endemically to some extent, but there has never been observed any widely-spread increase of it. These facts would suggest a drinking-water origin,<sup>1</sup> and might seem to imply the possibility that the specific cause of the disease, not improbably of vegetable nature,<sup>2</sup> may breed for a time in certain wells in great excess of its ordinary prevalence. They would further suggest that tolerance may be acquired by those resident in the district, and that it is new-comers who chiefly suffer. King Edward's School at Witley conforms to the rule in this, that it is in a locality which has been reputed to furnish a more than average proportion of goitres.

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<sup>1</sup> Mr. Berry, in his recent work, deals with this part of the subject rather briefly. He, however, avows his belief that water is the medium for the introduction of the element which is the cause of goitre and repeats the definite statement that there are wells in Switzerland to which young men, liable to serve as soldiers, resort in order to acquire goitres and with them immunity. Such statements should be very carefully examined.

<sup>2</sup> The idea that the cause of goitre may be an organic one is by no means novel. Various forms of diatoms, &c., have been suspected.

On the supposition that the cause of goitre is chemical and not vital, we have to modify the hypothesis and suppose that the water of some particular spring may in certain years contain more of the injurious ingredient than in others.

The treatment for cases of goitre of this kind is by the administration of minute quantities of iodine, or, according to some modern authorities, of thyroid extract. It is said that both these remedies, if given too freely, may induce atrophy of the gland.

Burnt sponge, formerly in great repute (see p. 200), contains in small quantities iodide of sodium, and bromide of magnesium. Lozenges of sponge—*trochisci spongiæ ustæ*—are still kept by some of our London druggists. Their supposed advantages over the medicinal employment of iodide of sodium is probably due to the smallness of the dose which they contain.

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### SPRENGEL'S SHOULDER.

THE publication, in our last number, of the photograph of a patient illustrating this deformity, has led to a very important suggestion from an illustrious observer. Dr. Hughlings Jackson, who has since examined our patient, brings forward the hypothesis that the deformity is, in part at least, due to muscular defect, and that it may possibly not be, in all cases, of congenital origin. He thinks that the malposition of the scapula is due to weakness, amounting to more or less complete paralysis, of the lower part of the trapezius, and has called our attention to an important communication on this subject which was published by him, with two photographs, in the *Illustrated Medical News* for February 2, 1889. This important paper, which is brief, we here reprint in full.

#### MALPOSITION OF THE SCAPULA FROM PARALYSIS OF THE LOWER PART OF THE TRAPEZIUS.

BY HUGHLINGS JACKSON, M.D., LL.D., F.R.S.

*Physician to the London Hospital and to the National Hospital for the Paralysed and Epileptic.*

I have seen paralysis of the upper part of the trapezius many times, but the case of this patient is the only one I have seen in which the lower part of that muscle was paralysed; the upper part of the muscle (the part supplied by the spinal accessory nerve) was intact. In all the cases I have seen of paralysis of the upper part of the muscle there has been clear evidence of intracranial disease; in this patient there is no sign of disease so placed. I showed the patient at the

Medical Society of London (*Lancet*, December 22, 1888). I now give some facts of the case, introducing two woodcuts from photographs taken by Bradshaw and Sons. I am very much indebted to my house physician (Mr. Roxburgh) and to my clinical clerk (Mr. Wainwright) for assistance in investigating the case. Dr. Beevor was so good as to see the patient with me.

The patient was admitted into the London Hospital under the care of Mr. Tay, and was transferred by him to my care. She was then in good general health and the local paralysis was the only symptom present.

The lower part of the trapezius did not act to faradisation; the same part of the fellow muscle acted well.

The lower angle of the child's left scapula is raised to about the level of the fourth dorsal vertebra, three vertebrae higher than the right one; it is nearer the middle line, and is "cocked out." The left supraclavicular space is deeper than the right. The latissimus dorsi acts to faradisation, but is supposed to have slipped off the inferior scapular angle; the serratus magnus acts too, but probably being at a disadvantage in the abnormal circumstances, its action is not so easily obtained as that of its fellow. To be mentioned as contributing to the deformity are the action of the levator anguli scapulae, which muscle is in great relief, and the weight of the arm.

The patient had a fall on her back in October, 1887, which did not hurt her at the time, though she had pain in the middle of the back a few days later, and her mother then noticed that the left shoulder "stuck out," but said that the child had been "on one side" about two years before. Mr. Wainwright has produced in the dead subject a deformity like that this girl presents by cutting away the portion of the trapezius extending from the root of the spine of the scapula to the twelfth dorsal vertebra, together with the lower strands of the serratus magnus.

A full account of the peculiarities of such a case is to be found in Duchenne's "Physiologie des Mouvements," chap. 1.

I have nothing to say of the pathology of the case.

Further examination of Dr. Travers Smith's patient whose case we have reported, at a consultation in which Dr. Jackson and Dr. Beevor were good enough to assist, undoubtedly establishes the fact that the lower part of the muscle in question is weak. It is not absent, nor is it actually paralysed (for its strands can be demonstrated in action), but it is decidedly defective. It may easily be the fact that in the examples of this deformity which have been recorded abroad, the muscular system has not been examined with sufficient care. Nothing is, in fact, easier than to overlook the defect to which Dr. Jackson has drawn our attention. In none of the cases hitherto published is there evidence that the state of this part of the trapezius had been investigated.

Should it be established that the muscular defect referred to is an important, or possibly the chief, element in determining the malposition of the shoulder blade, we shall still have much in the totality of "Sprengel's Shoulder" needing elucidation. The diminished size of the bones chiefly concerned, the want of symmetry in

the face, and its not infrequent association with defects of development in other regions, would remain unexplained. It may still be that the whole group, including the paresis, are of common origin as associated defects in development. On the other hand, it is not impossible that a muscular paralysis, followed in very early life by malposition of parts, might lead to some local defect of growth.

Should subsequent investigation prove that the condition is after all a consequence of muscular paralysis, we may have to change its designation to "Hughlings Jackson's Shoulder," or to go still further back and name it after Duchenne.

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#### DISAPPEARANCE OF LEPROSY FROM THE FAROES.

THE disappearance of leprosy from the Faroe Islands, whilst it has persisted in Iceland and on the Norwegian coast, is a circumstance of great interest. We have abundant documentary evidence of its former prevalence in these islands, but nothing that helps us much to the explanation of its disappearance. There is, in fact, no record of the special conditions under which it vanished. That it prevailed and even increased in spite of the institution of leper homes is certain.

Dr. Ehlers thinks it certain that a leper house existed before the Reformation, and that another was founded at Arge shortly after that epoch. In the original one he estimates that there were usually ten or a dozen lepers. He writes: "The hospital seems to have been insufficient for the demand, and no attention was paid to the rules as to obligatory isolation." He gives us, however, no evidence as to the existence or nature of such rules. Leprosy continued to prevail, and it was necessary to issue a decree in April, 1661, ordering that lepers should be interned in a home, and the bailiffs were to take a census of lepers and build them a home at Arge. This brings us down to a date nearly a century after the spread of Protestantism. Half a century later still there were yet lepers in Faroe, and at the old hospital at Thorshavn it is on record that there were fifteen sick inmates "from 1709 to 1710." According to Hirsch it was in the middle of this, the eighteenth century, that leprosy died out in the Faroes. The group consists of sixteen

inhabited islands, with an aggregate population of about 9,000, and leprosy left them all.<sup>1</sup> So far as is known there is not at present a single leper to be found in any. This is a very remarkable fact when we remember that so recently as 1661 a decree ordering the building of a home had commenced with the statement: "Considering that in the whole country there are a number of persons attainted with leprosy, and that the number of lepers increases incessantly, insomuch that it is to be feared that the contagion will gain ground to such an extent that we shall be unable to stop it." Thus it would appear that between the acme of its prevalence and its total extinction scarcely 100 years intervened. We have here a sort of battle-field upon which the believers in contagion and advocates of isolation may fairly meet those who deny contagion and believe in food-causation. May we beg of Dr. Ehlers to give up another summer holiday and to collect every fact that he can obtain in illustration of what was taking place in the Faroes during that century. The contagionists may fairly allege that the government had become alarmed, had ordered a census of lepers, and had built a new leper house. They may urge that we have a good instance of the success of segregation. There are, however, we fear, many slips between their lips and the cup of triumph. We have no reason to believe that any rigid search was continuously made, or that when found lepers were deported from island to island. There existed no medical police adequate to such a crusade. We know well that, if it had been attempted, only aggravated cases would have been detected, and that even these would often have been carefully concealed by the sufferers' relatives. We know also that such measures carried out in our own day in the Sandwich Islands with almost brutal consistency, and with every advantage as regards skilful diagnosis, have utterly failed. Further, we know that leprosy was leaving the Orkney and Shetland populations at precisely the same period, and that in these islands no measures of compulsory isolation were in force. It is also the fact that in Iceland and on the coast of Norway the disease has persisted in almost full vigour, although these countries were then and are

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<sup>1</sup> For some medico-geographical facts as to the Faroes, see POLYCLINIC, vol. iii., p. 185.

now quite as well provided with leper hospitals as were the Faroes, and that they repeatedly tried the efficacy of census-taking. Those who believe that leprosy is a food-disease and that isolation measures exercise no influence whatever on its prevalence, are entitled to remind us that the century with which we are concerned was that during which potatoes, turnips, and other root crops found their way to the islands in question, and to insist that these islands are at the present day well supplied with fresh meat and vegetables, and fuel to cook them with, articles which to the Icelanders and the Norwegian fishermen are still *desiderata*. Nothing is more likely than that the practice of eating badly-cured and half-cooked fish may have ceased in those regions which have got rid of leprosy and still prevailed in the others. Such has indeed, it is well known, been the case. It may have been that the importation of dried fish from Norway came to an end at this time, or that some local industry of that kind terminated. These are conjectures, but they indicate the lines along which an enquirer should proceed.

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#### PITCAIRN ISLAND AND ITS INHABITANTS.

THE Island of Pitcairn and its inhabitants have for more than a century claimed the interest of the British public to an extent far exceeding their intrinsic importance. It is a tiny island three miles long by two broad, and its population has never exceeded a few hundreds. It has, however, presented opportunities for observation in various directions, and some of them of a kind to claim the notice of our own profession. It is not, like most of its neighbours, a coral island, but wholly of volcanic origin ; it has no lowlands. It has no springs and its inhabitants depend entirely upon rain water. Its population is the result of a cross of English and Tahitian blood, no European women having ever been introduced. The mutiny of the *Bounty* was indeed probably brought about by the unwillingness of Captain Bligh's sailors to leave their Otaheitan consorts, and the first settlement on Pitcairn consisted of nine Englishmen, six native men, and twelve women. Although the occupation of the island by the descendants of these has not been continuous, yet it is probable that no material introduction of European blood has

since taken place. Once, in fear of drought, the whole population migrated to Otaheite, and after return to Pitcairn it was at a later period transferred by the English Government to Norfolk Island. The attractions of Pitcairn, however, again proved too strong to be resisted, and two or more families returned to it. From these the present inhabitants are descended. We have therefore an instance not only of the mixture of two very different races, but of the occurrence of intermarriage continued through several generations. The original settlement was in 1790, the last return, 1858. As might have been expected from the miscreants who had effected the mutiny, the early years of the colony were full of crime and misery. Improvement, however, gradually ensued, and the mixed race became a quiet, industrious, and even moral community. The subjoined extracts, which are taken from a Government report just published, supply interesting details as to their present condition :—

“ Supplies of the following things are abundant :—Poultry and goats. The latter the islanders will either shoot or drive in from the hills, and the young goats, of which we took a large number, are excellent. There are two herds of these, each numbering about 100. Cocoanuts, bananas, pineapples, marsh and watermelons, limes, oranges, mangoes, pumpkins, coffee, tomatoes, sweet potatoes, Indian corn and arrowroot.

“ Disease appears to be still almost unknown. The typhoid of 1894 was brought here by a shipwrecked crew, and no other epidemic has touched the island since. The leading people prefer to continue, as hitherto, without medicines of any sort. One small boy has recently been killed by a fall whilst chasing goats on the cliffs. Thursday October Christian, son of the man of the same name and grandson of Fletcher Christian, master’s mate of the *Bounty*, is the oldest man on the island, aged now 83; two other men are now over 75, and the oldest woman is 72. None of these old people suffer from anything beyond the weakness of old age, and all seem thoroughly contented and happy. The early loss of the front teeth in the upper jaw continues amongst many of the islanders; but the teeth of numbers of adults, as well as of the children, are without a flaw. No one smokes or uses intoxicating liquors. Men, women and children seem, without exception, in robust health and full of vigour.”

The “ overflow of women everywhere,” about which Mr. Robert Browning and Sir Frederick Treves have so ungallantly complained, would appear in this small community to be felt as a real inconvenience. The report continues :—

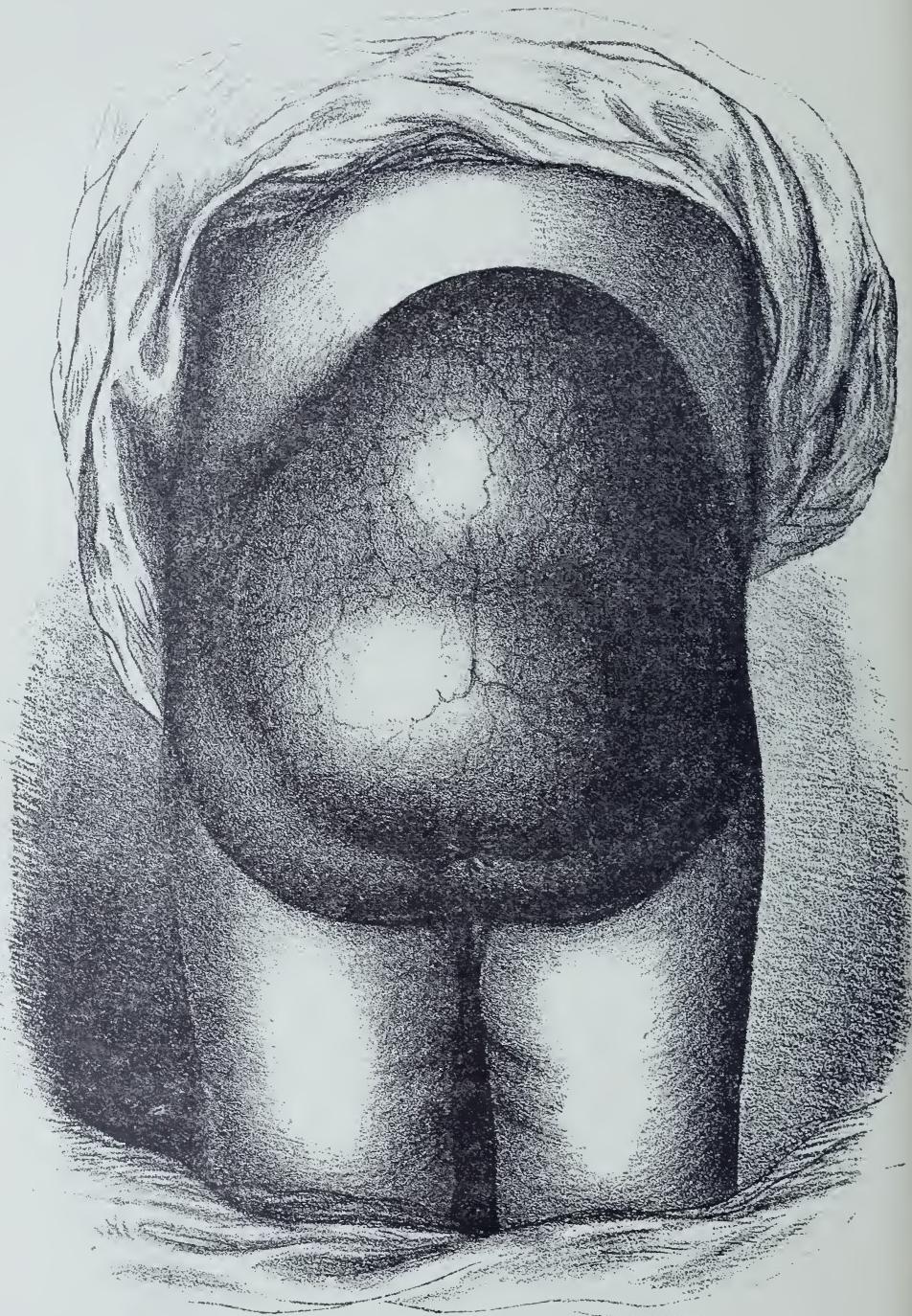
“ The surplus of females in the present and rising generation presents a difficulty naturally accentuated in a small and secluded community. Any arrangement which would include the removal and care of some of these youthful females —of whom some of the grown-up ones would now willingly leave—would be a work of useful philanthropy.”

## SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

### THE CYSTIC COCCYGEAL TUMOUR.

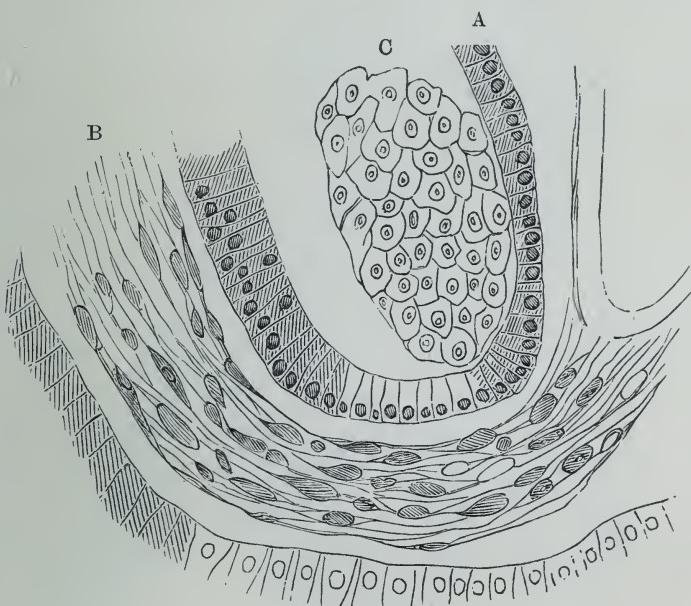
BY JONATHAN HUTCHINSON, F.R.S., LL.D.

GENTLEMEN.—Will you allow me to mention briefly the case of a patient whom I am not able to produce before you. I shall be able to illustrate her case by portraits which show a parallel condition in others, but no persuasion of mine could induce Mrs. W. either to come here for demonstration or to allow herself to be photographed; nor is her reluctance much to be wondered at. She is the subject of an enormous coccygeal tumour which projects under her clothes and gives her an exaggerated type of Hottentot beauty. It has been present from her birth, and has only very slowly increased. Its increase has, however, been steady, and with it the inconvenience caused, and hence the reason why, at the age of 45, she has for the first time sought professional advice. The tumour hangs below her buttocks, but merges with them, projecting upwards over the midsacral region. It is in the middle line, but its right half is much larger than the left; this is due probably to the development of some large cysts, for fluctuation over a very considerable area can be detected there, whereas in other parts it is much more limited. The tumour apparently consists of a great number of cysts of very various dimensions and with much solid structure intervening. On its upper part it is somewhat lobulated, but in most others its boundaries are fairly smooth. In most parts it is not adherent to the skin, but there is an area near its middle where, as a consequence probably of pressure, the skin is fixed and shows signs of irritation. When seated it is directly under the trunk, and the woman sits as if perched on a thick cushion. The displacement of the anus is a very conspicuous feature. This opening is dragged backwards on the under surface of the mass, and the rectum is easily felt as a thick tube for a course of six inches or



Coccygeal Tumour as seen from behind. Note the displacement of the anus. (From Hutchinson's Clinical Illustrations, vol. ii., p. 36.)

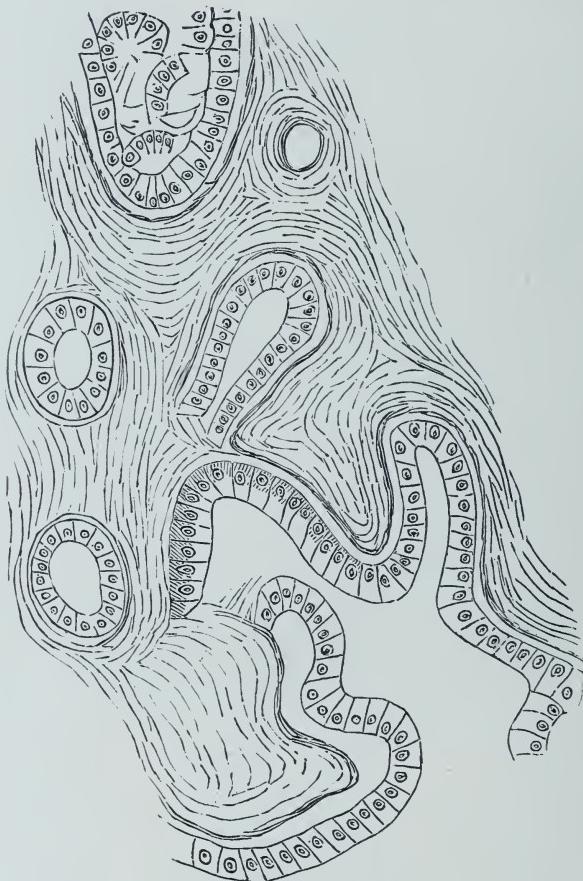
more. I attach great importance to this dragging down of the lower bowel, since it conclusively proves that the tumour is a coccygeal one and not a spina bifida, nor probably one enclosing foetal structures. The cystic coccygeal tumour, of which I feel no doubt that this is an example, begins in structures (Krause's gland?) placed just under the coccyx; it grows upwards and downwards, surrounds the coccyx and drags downwards and backwards the



(A) Columnar Epithelium of Tube. (B) Delicate Connective Tissue of Matrix.  
 (C) Clump of Spherical Epithelium in Interior of Tube. (Dr. Stephen Mackenzie.)

lowest part of the gut, which is loosely embedded in it. These conditions you will see well illustrated in the plates which I exhibit. They are taken from my own Atlas of Clinical Surgery and were published fifteen years ago. The case to which they belong was that of a child who was placed under my care by Dr. Stephen Mackenzie, when we were colleagues at the London Hospital, and was, I believe, the first of its kind which had been described in detail. The child died, and I made a careful dissection with the special object of determining whether it would have been practicable to have excised the mass. My conclusion was that with care it might have been taken away without wounding the peri-

toneum, the rectum, or any important structure. A lobe of the tumour passed upwards into the hollow of the sacrum and in contact with the peritoneum, but its adhesions were loose and it might have been enucleated. Since then, by other surgeons, several successful excisions of these tumours have been performed. Some



*Section of Tumour showing Tubes lined with Epithelium. (From a drawing by Dr. Stephen Mackenzie.)*

drawings from two cases operated upon by Dr. Mackay, of Huelva, have been placed in our Museum. I have not myself ever seen another example of this form of coccygeal tumour in an infant, and the case which I have to-day described to you, is, I believe, the first which has been identified in an adult. I say identified, advisedly,

for we have two portraits in the Museum which may not improbably be taken from examples of it, but in neither of them have we data for diagnosis. One of them, a photograph of a young woman, has been regarded as an example of spina bifida, but from the position of the tumour, looks more like one of these growths. In the other, a sketch from the late Mr. Partridge's collection, I have no history whatever.



*A Coccygeal Tumour.*

Our present case is important, because it gives us proof that these tumours when left alone, do not run a malignant course, nor in fact cause their possessors very much inconvenience. Those who examined microscopically the structure of the tumour in my first case, were of opinion that it would have proved malignant, and regarded its histology with great suspicion. It would appear from our present case that there is a tendency for the cysts to enlarge, but not for increased growth of the solid elements. I show you some drawings (*see pages 171 and 172*) which were made from sections prepared by Dr. Stephen Mackenzie and which were published with my original paper. I also show you some drawings from similar cases.

## NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

### MEDICAL CASES.

BY HARRY CAMPBELL, M.D., F.R.C.P.

*September 24, 1901.*

#### I.—*Ocular Symptoms in Tabes Dorsalis.*

THESE were illustrated by two male patients. In one the ataxia was extreme, the patient being unable to walk without the assistance of a couple of walking sticks. This man had well-marked ptosis on the right side. The other patient was also distinctly ataxic, and in him the pupils were extremely small and showed no response to light. In these two instances the prominence of the spinal symptoms left no room for doubt as to the diagnosis, but in each case the ocular conditions were valuable confirmatory evidence. Their importance, however, is not due merely to their confirmatory value. They may, indeed, be the first symptoms of the disease. This is true, both of an ocular paralysis and of the Argyll-Robertson pupil. A ptosis, or a paralytic squint, developing in a middle-aged man is thus a danger signal, and ought to be regarded in this light. The fact that such a paresis is transient, does not lessen its significance, for it is frequently found that this is the character of the ocular paralyses which herald the onset of tabes dorsalis. Similarly an Argyll-Robertson pupil, or inequality of the pupils, may be an early event in a patient who at a later stage becomes characteristically ataxic. Inequality of the pupils is, no doubt, sometimes a congenital peculiarity, but unless explained in this way, its existence, even as an isolated fact, justifies a suspicion of commencing central nervous disease. That disease may be tabes dorsalis, or it may be general paralysis of the insane.

## II.—*Heart Disease in Childhood.*

Three patients, of ages ranging from 5 to 13 years, each the subject of mitral disease, were examined. The physical facts formed a graphic exhibition of the enormous enlargement which the heart may undergo in childhood. In one instance the left border fell some four inches outside the left nipple line, and the right border about two inches to the right of the middle line. The explanation is not merely that hypertrophy is produced in response to the strain due to the valvular flaw; the result arises from the fact that, more especially in childhood, not only the endocardium or pericardium is involved in the disease, but also the myocardium. The muscular tissue, therefore, yields, and the cavities of the heart become greatly dilated. One of the patients was very anaemic, and it was pointed out that anaemia in childhood is a frequent expression of rheumatism. Perhaps the most important clinical lesson which the cases enforced was brought out when the personal histories of the patients were considered. With one exception these gave little or no record of rheumatic incidents, yet there could be no doubt that in each case the heart disease was due to rheumatism. Practically, heart disease in childhood, unless congenital, is always rheumatic in origin, and it may, and often does, occur without any of the joint phenomena that form so striking a feature of the rheumatic fever of adults. Hence the great importance of remembering that a mild febrile attack, slight joint pain, or so-called "growing pains," may in a child mean rheumatism and a serious risk of organic heart disease. To insist upon complete rest from the outset of such conditions is therefore an obvious duty.

A question discussed in connection with these cases was the effect of the cardiac enlargement on the shape of the chest. In the first place, it was shown that a degree of praecordial bulging was produced, the yielding ribs of the child allowing this to take place. In the second place, the cardiac enlargement must needs mean invasion of the pulmonary space and the diminution of the respiratory area. To compensate for this there is over-action of the inspiratory muscles. The clavicle and upper ribs are drawn upwards and fixed by the sterno-mastoids and scaleni; the antero-posterior diameter is increased; and the entire chest is brought as it were permanently into an advanced inspiratory position.

### III.—*Neuritis after Influenza.*

The patient, a girl of 15 years, had an attack of influenza twelve months ago. Subsequently she suffered from attacks of pain in the left thigh which were regarded as sciatica. She now complained of defective power and loss of sensation in the left lower limb. Examination showed considerable atrophy and weakness of the muscles of the thigh, loss of the knee-jerk, and impaired sensibility. The muscles below the knee were not affected. The various conditions capable of causing the muscular atrophy were considered. Hip-joint disease was excluded, as the movements of the joint were perfectly free, and manipulation produced no pain. Infantile paralysis would explain both the atrophy and the loss of the knee-jerk, and pain is occasionally a feature of the disease; but the history of the case was quite opposed to such a diagnosis. In infantile paralysis the atrophy and paralysis do not occur as gradual and coincident events, but the paralysis is of sudden origin, and is usually complete, and the wasting follows at a later date. Progressive muscular atrophy in this case need hardly be considered. It does rarely commence in the muscles of the thigh, but it is not accompanied by pain or sensory defect, and it is very rare indeed under 25 or 30 years of age. The symptoms of the case point directly to a neuritis. The pain, followed by impairment of sensation, shows that the sensory nerve fibres, after a period of irritation, have lost some measure of their conducting power; and the muscular paresis and atrophy indicate that the transit of motor and trophic influences is also imperfect. The muscular wasting is too great to be explained by the relative disuse of the limb. The case is not one of peripheral neuritis such as is produced by alcohol, arsenic, and other toxic agents, for in these the symptoms are bilateral and symmetrical. It is one of local or asymmetrical neuritis, the changes being probably, at least in the first place, in the interstitial fibrous tissue and not in the nerve fibres themselves.

An encouraging prognosis was given, and treatment by massage and galvanism advised.

*IV.—A Case of Progressive Muscular Atrophy.*

This case offered an effective contrast to the one just described. The patient was a man of 49 years. For four years he had been conscious of gradually increasing loss of power and wasting of his upper limbs. There had been no pain, and sensation was unimpaired, and the muscular defects exhibited a high degree of symmetry. The wasting involved most of the muscles about the shoulder joint. Atrophy of the deltoids was extreme, and the supraspinatus, infraspinatus, biceps and triceps on each side, were all more or less wasted and paretic. Below the elbow the extensors of the wrist were weak, those in the left forearm to such an extent as to produce marked wrist-drop. In such a case it was necessary to consider the possibility of lead poisoning, for lead, like the poison of diphtheria, produces a peripheral neuritis in which the motor fibres are involved and the sensory fibres escape. In the peripheral neuritis due to alcohol and to arsenic, on the other hand, both motor and sensory fibres are attacked. The patient, however, was free from all evidence of lead poisoning, and his occupation did not expose him in any way to the influence of lead. The chronic course of the disease, the gradual and coincident development of atrophy and loss of power, the absence of sensory phenomena, and the symmetry of the manifestations, were exactly what occurred in progressive spinal muscular atrophy. It is true that the earliest muscles to be attacked in that disease are usually those of the thenar eminence and the interossei, and that in the present case the muscles of the hands appear normal. But occasionally the disease commences at the proximal extremity of the limb and more especially in the deltoids. The case must therefore be placed in this group. Massage, and the hypodermic injection of strychnine, are the most useful measures in the way of treatment, but the prognosis is by no means a hopeful one.

Among other patients demonstrated were: (1) Two women the subjects of intracranial disease; (2) a young woman having the three classical features of Graves's disease, but without loss of flesh and with relatively little general nervous disturbance; and (3) a middle-aged man with an abdominal tumour, probably growing from the anterior wall of the stomach.

## DISEASES OF THE EYE.

BY MR. WORK DODD, F.R.C.S.

*Friday, September 27, 1901.*CASE I.—*Injury to the Eyeball.*

ONE of the immediate effects liable to follow a blow on the eye was exhibited in the case of a man who had been struck by a small fragment of wood flying off at a tangent from a circular saw. At first, the only evidence of injury that could be detected was a minute blood-clot in the periphery of the iris at the upper border. On absorption of the clot, however, it could be seen that there was a small rupture or detachment of the peripheral fibres of the iris. This condition (iridodialysis) is a recognised result of blows on the eye. When limited, as in the present case, it is not in itself of any great moment; for though an opening is formed through which, in addition to the pupil, light may reach the retina, it is unusual to find any disturbance of vision. Such an injury, however, shows that considerable violence has been applied to the eye. And the effects of violence, though slight apparently at the time, may in their more remote manifestations be extremely serious. One of these may be detachment of the retina. Another possibility is the development of a neoplasm. And these consequences may not appear until six or twelve months after the injury. From this an important practical rule follows, viz., that any medical certificate bearing upon the condition of an eye which has been subject to violence must be phrased in cautious terms. It is never safe to say until perhaps a year has elapsed that the consequences of the injury are exhausted. Unless this is remembered the legal claims of the patient for compensation may be prejudiced.

The treatment in the present case had been atropine and bandaging. The atropine by paralysing the sphincter of the iris lessens the strain upon the periphery and so diminishes the risk of extension of the detachment. The bandage secures rest for the eye. It is usually a wise measure after an eye has been subject to much

violence, to keep the patient in bed for a time. The rest not only facilitates the processes of recovery, but probably lessens the risk of early retinal detachment. The use of saline aperients by lowering blood pressure exerts an influence in the same direction. An immediate escape from serious consequences still leaves the possibility of unfortunate developments in the future.

*CASE II.—Bilateral Ptosis Improved by Operation.*

The patient was the subject of paralysis of all the external and internal muscles of each eyeball (ophthalmoplegia externa and interna). The double ptosis had of course been a most serious inconvenience, and when first seen the man carried his head thrown far back in his endeavour to peep under the edges of the pendent upper lids. Medicinal treatment by mercury and potassium iodide had failed to relieve him much, at least in this respect. The surgical measures adopted had been the insertion of three sutures near the edge of the upper lid, these being carried under the skin and brought out at the level of the eyebrow. When tied, the lid was drawn up, and on the removal of the sutures, after some seven days, the cicatricial tissue formed in their tract was sufficient to keep the lid raised to such a level that the patient could see under its edge without throwing his head back on his shoulders.

*CASE III.—Optic Atrophy, Loss of the Knee-jerks, and Sciatica in Diabetes Mellitus.*

The patient, a middle-aged man, had been known for at least a year to have a considerable quantity of sugar in his urine, and he had been losing flesh. For some months he had been conscious of failing vision, and he came hoping to have this improved by spectacles. Failure of vision in diabetes may of course depend on cataract, or it may be due to changes in the retina not always distinguishable from those which sometimes accompany renal disease. But neither of these conditions was present in the present case. The lens and the other media were quite transparent. The retinae appeared normal to ophthalmoscopic examination. On the other hand, the optic discs were very white, with clean-cut edges. The appearance was that of primary optic atrophy, and this diagnosis was confirmed by the failure of vision. There were in the case

two other illustrations of the effects which may be produced in the nervous system by diabetes. The first was absence of the knee-jerks, a not infrequent event. The second was a history of sciatica. On questioning the patient concerning his recent health he volunteered the remark that he had been much troubled with sciatica which had attacked both limbs. Interstitial inflammation of the peripheral nerves has long been recognised as one of the complications of diabetes. In this way are explained both the absence of knee-jerk and the sciatica. Saunby has pointed out that the latter, especially when bilateral, is especially suggestive of diabetes.

The other cases demonstrated included : (1) A man having several openings (congenital) in each iris (the case is figured and described in the *Ophthalmological Society's Transactions*, vol. xiv.) ; (2) a boy in whom epiphora was not relieved by operation on the tear duct, and who was subsequently found to have an abscess in the maxillary antrum ; (3) two examples of interstitial keratitis.

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## DISEASES OF THE NOSE AND EAR.

BY MR. R. LAKE, F.R.C.S.

*Friday, September 20, 1901.*

### CASE I.—*Case of Fronto-Ethmoidal Cell.*

THIS patient is one that I had the pleasure of demonstrating at a previous consultation. It is a case of disease of a frontal cell, and was under the care of my colleague, Dr. Frederick Spicer. He has, as you see, operated successfully. He found there was no communication between the cell and the nasal cavity, this having become quite obliterated. He made a large opening into the middle meatus ; which, however, has closed again, and the cavity has been allowed to fill from the bottom. It is probable that this was a fronto-ethmoidal cell, and that the patient has on this side no frontal sinus ; or, if he has, it is connected with, or part of, that on the opposite side.

*CASE II.—Aural Polypus with Vertigo.*

The next patient is a woman of 28 years, who gives a somewhat vague history of discharge from her left ear, and is also under the care of Dr. Frederick Spicer. You will see that the major part of the tympanic membrane is destroyed. The whole handle of the malleus is visible. A small amount of the membrane in front, and a narrow ring round the edge, is all that remains of the drum. Hanging down from beneath the remains of the membrane, behind the handle of the malleus, you will observe a small polypus. We must now see whether there are any indications for operative interference, and from the patient we learn, that after syringing her ear, she has an attack of vertigo, which lasts sometimes for as long as two hours. From this we learn that the bony external semicircular canal on this side is probably eroded; this is an indication for operation; but it is an open question whether removal of the remains of the drum, ossicles, and external wall of the attic, with free curettement, is sufficient; or whether the radical mastoid operation should be performed.

*CASE III.—Sclerosis of the Middle Ear.*

Our next case is an old lady of 58 years, with long-standing deafness, rapidly increasing. She hears, as you will notice, the tuning fork longer when placed on her mastoid, than is normal. Her membranes are opaque, showing that the drum is thickened. Both the drums are also much indrawn. This, combined with her want of air conduction, shows us that the case is one of chronic sclerosis of the middle ear. Under ordinary circumstances, a person of 58 years of age would be losing the power of bone conduction.

*CASE IV.—Enchondrosis of the Septum Nasi.*

Our last case is a young man of 25 years, with marked nasal obstruction. By anterior rhinoscopy, with which we must be content, we are able to observe that he has an enchondrosis on either side of the septum, and marked hypertrophic rhinitis, the inferior turbinate body on each side reaching to the floor of the nasal cavity; but he has also great obstruction at the choanæ from enlargement of the posterior ends of the turbinates. I shall remove these ends, reduce his turbinates in size, and expect, by this means, to give him efficient nasal respiration.

## OUR CLINICAL WORK: A RECAPITULATION.

*Elephantiasis and Elephantoid Hypertrophy (continued from page 152).*

One case deserves especial mention inasmuch as an upper extremity was the part affected, which is very unusual. Its subject was a married woman, evidently of mixed negro blood, who had been born in South America. She was in good health, but the whole of her right upper extremity was larger than the other from fingers to shoulder. The skin was quite smooth and pale, and only slight evidences of oedema existed. The history was that the limb was liable to increased swelling every few months (the so-called Elephantoid fever<sup>1</sup>). It was, when we saw it, at its best. The first attack was said to have been attended by considerable swelling of the hand and forearm, and streaks of redness. Thus, on the whole, the evidence favoured the belief that the condition was the result of recurring erysipelas rather than of parasitism, although the patient was from an elephantiasis country. There is much as to the relationship of these two forms of causation which needs to be worked out.

*Osteoid Tumours of the Skull.<sup>2</sup>*

Three examples of large osteoid tumours on the skull have been examined. In two of these the subjects were men who at a distant period (some years) gave the history of severe blows on

<sup>1</sup> In reference to this fever the following extract from Colonel McLeod's syllabus is of interest.

"*Phenomena.*—(1) Periodical attacks of pyrexia (so-called 'elephantoid fever'), preceded and accompanied by adenitis and erysipelas-inflammation of parts beyond (lymphadenitis and lymphangitis) and lasting for a few days; often preceded by rigor and terminating by crisis; such attacks regular (mensual or bi-mensual) or irregular. (2) Increase of local swelling after each attack of fever; tumour continues to grow with or without fresh fever from lymph stasis and gravitation. (3) Two kinds of tumour—solid and spongy; latter sheds milky or lymphy ooze. Growth of feeble vitality, liable to attacks of inflammation, abscess or gangrene."

<sup>2</sup> See vol. iv., pp. 25, 198 and 270.

the head. In one of these the tumour was hard and growing slowly, and in this the patient remains *in statu quo*. In the other it was growing fast and was much softer. No special treatment could be recommended, and the man, having returned to his home in Wales, died a few months later. There had been fungation and sloughing of large masses. The third case was of great interest because it was in association with bronchocele. The patient, an elderly woman, had been the subject of enlargement of the thyroid for many years, and latterly it had increased rapidly and caused symptoms of tracheal compression; she had also the aspect of myxoedema. She died from laryngeal spasm a week after her attendance at the Polyclinic, and the autopsy showed that the growth was of soft consistence and had perforated the skull.

### *Lupoid Syphilis.*

A great many examples of lupoid affections of the skin in tertiary syphilis have come under observation, some of them very extensive, and many multiple. Interesting questions of diagnosis have repeatedly presented themselves. Those who believe that "syphilitic lupus" occurs chiefly, if not solely, in tuberculous subjects, found in some of the histories given much confirmation of their views. The use of iodoform, chinosol, and iodides internally, received, as might be expected, frequent and very definite illustration.

### *Raynaud's Phenomena.*

Of Raynaud's phenomena we have had several important examples, and amongst the drawings which have been preserved are two which show a symptom perhaps not previously observed. It consists in the formation of a narrow band of thrombosed vessels under the nail, just at the distal attachment to its bed. This has been observed in three cases, all of them examples of the chronic form. The value of small doses of opium frequently repeated and long continued has been well illustrated in at least one of our cases.

*Gangrene in Diabetes.*

Recurring gangrene of the toes in association with diabetes has had an illustration in the case of a man, who for many years had been the recognised subject of the latter malady. For long he maintained his general health, and the manner in which the wounds left by the detachment of his toes healed was very remarkable. Latterly, however, his strength has failed.

*Leprosy.*

Probably not fewer than twelve different patients have attended at the Polyclinic during the past two years for demonstration of the phenomena of leprosy, and some of these have attended repeatedly. With two exceptions, all have been Europeans of pure blood who had resided abroad in leprosy districts. Attention has been frequently drawn to the facts that the patient seldom or never admits having run any risk of contagion and often denies having even ever seen a leper, and that in no single instance was there any recognition of an initial sore. Most of our cases have been in the macular stage, but in one, which in the first instance was only such, and in whom the patches were remarkably superficial, the face has gradually developed tubers. The similarity of the malady to certain forms of lupus and the great probability that it is really in relation with tuberculosis has been repeatedly discussed. A drawing has been made with the especial object of demonstrating that the thickening of the lobule of the ear in leprosy is indistinguishable from that which occurs in lupus vulgaris. It is, however, rather with lupus erythematosus that a more close affinity has been pointed out. The treatment recommended has been usually a very liberal diet and continued small doses of arsenic, but in some instances mercury has been given. It is worthy of note, and we can only hope that it will not greatly alarm our contagionist friends, that all these patients are at present residing with their friends in England, and that no special precautions as regards isolation are being observed. Several have been inmates of the wards of various hospitals where they were allowed to mix freely with other patients.

*Coxa Vara.*

The condition upon which the name of Coxa Vara has recently been bestowed has been carefully studied in one very characteristic case and in one or two others which were less so. In this affection the neck of the femur or, perhaps, the epiphyseal cartilage in young persons, undergoes a sort of inflammatory softening, without material pain and without tendency to abscess. As a consequence the shaft of the bone travels upwards, and the neck, instead of slanting upwards, may be horizontal or even slant downwards. Then the patient recovers, takes to a high-heeled boot, and goes about almost as well as ever. Our case was that of a lad of 18, sent by Dr. Stocker of Forest Gate, who came to us on several occasions. He had been confined at home to the couch for two months with lameness, and then recovered with his great trochanter more than an inch too high, the foot slightly everted, but able to walk well. The movements at the hip were free and he now goes about as well as ever—making allowance for his shortened limb. He had had no injury, and his pain was at no time severe.

*Unilobular Cirrhosis of the Liver.*

There has been at least one opportunity of considering a case of this comparatively rare form of hepatic cirrhosis. The patient was a well-nourished woman of 56 years of age, whose liver was considerably enlarged and granular, but neither tender nor nodulated. She had suffered from jaundice for nearly a year but had never had either oedema or ascites.

The urine was reported to be deeply stained with bile, but the faeces, though pale, were not without colour. She was subject to frequent attacks of mental depression, and had once or twice experienced alarming sensations of "light-headedness." There was no history of alcoholism, and the patient did not present the appearance of a person addicted to habits of excess.

*Friedreich's Ataxia.*

A complete series of cases of this disease was presented by Dr. Guthrie Rankin at one of the medical demonstrations. The patients were three girls, aged respectively, 18, 16, and 11, who

belonged to a family of four, the remaining member being a brother, whose health was reported to be satisfactory, but who stammered badly. The parents were first cousins, but the family history otherwise was unimportant. The two elder girls presented between them most of the characteristic features of the disease; the foot deformity was very marked in the elder of the two, and the spinal curvature no less striking in the younger. Each had experienced, as her first symptom, a difficulty in getting upstairs, and in both this had declared itself at about 12 years of age. The youngest sister, who declared herself to be perfectly well, has not yet quite reached the age of disease incidence, but already she presented these suggestive symptoms: Slight lateral curvature of the spine, hyper-extension of the phalanges and commencing foreshortening of the feet, such feeble knee-jerks that they could hardly be elicited, and fine tremor of the facial muscles when put in action. The general health in all three girls was excellent, and the elder two believed they would speedily be quite well if they could but regain the former vigour of their limbs, and get free of giddiness and a tendency to unsteadiness of gait.

#### *Contrasted Cases of Disease.*

At several of the medical consultations, it has happened that cases have been investigated together, which, though more or less closely resembling one another, were examples of widely different diseases, and thus admitted of graphic demonstration by contrast. To mention only a few that have been before us: Anterior poliomyelitis in comparison with infantile hemiplegia, where a spinal could be contrasted with a cerebral lesion; Addison's disease and pernicious anaemia; congenital heart disease and valvular disease, the result of endocarditis; bronchiectasis and phthisis with physical signs of cavity the outstanding feature of both conditions; disseminated sclerosis and functional disease; locomotor ataxia and ataxic paraplegia; athetosis and chorea, &c.

In these, and many other such cases, there is often considerable difficulty in arriving at a conclusion when the case is seen alone, but when looked at in the light of contrast, the points of difference become impressed on the observer's mind, and help to bring into

bolder relief the essential features by which the one condition is to be recognised from the other. Obviously such occasions must be of value as the best of all opportunities for forming or perfecting a differential diagnosis.

*Lancereaux's Treatment of Aneurism by Gelatine Injections.*

The recent interest in, and perhaps distrust of, the treatment which was aroused by an inquest at Guy's Hospital on two patients who died there from tetanus occurring in the course of treatment for aneurism by this method, may be counterbalanced by other cases in which highly successful results have been recorded. In passing, it may be remarked that it is difficult to conceive where the tetanus bacillus came from; its most likely source was the gelatine, but surely the sterilising process ought to have destroyed it. Wherever derived, its presence was accidental and did not stand in any direct cause-and-effect relationship to the treatment.

In two cases of aneurism related by Dr. Guthrie Rankin, at the Polyclinic during the past year, the injections were unattended with evil effect, and the results were at least so far satisfactory that both subjective symptoms and objective signs greatly improved. Both patients were men at middle life, and one of them was brought forward for examination both before and after his course of treatment. His aneurism was situated in the ascending arch of the aorta, and gave rise to a prominent pulsatile swelling in the second and third right interspaces. The chief complaint was of severe pain, breathlessness on exertion, and attacks of "fainting." The second case presented the usual signs of an aneurism in the first part of the ascending arch, and the leading subjective symptoms were pain, which at times became agonising, and frequent attacks of angina pectoris. Both were treated at first by the usual methods of rest, dry feeding and iodides, but without notable improvement, and in one morphine had become a matter of daily necessity.

Both patients began to improve after the second injection, and eventually the pain wholly disappeared and all the other symptoms became ameliorated. In the first case, where pulsation was a prominent feature, it practically disappeared, and when the patient was last heard of a few weeks ago, he continued free from discomfort and was about to resume work. The second man was a foreigner,

and has not sent any report of himself since he returned to his own country.

The injections were delivered once a week into the deep tissues of one thigh, alternately with the other, by means of a large glass syringe and medium-sized needle. The gelatine was dissolved in saline solution, and injected slightly warm. Careful measures of sterilisation were adopted. It was found impossible to reach the large quantity advocated by Lancereaux, but  $3\frac{1}{2}$  ounces containing 30 grains of gelatine were used at each time. Slight constitutional disturbance lasting for about twenty-four hours followed most of the injections, but the temperature never rose beyond  $100^{\circ}$  to  $101^{\circ}$ , and after two days in bed the patient was allowed to move about.

#### *Transposition of Viscera.*

Two examples of this departure from the natural order of things have been reported ; in one the whole viscera were transposed, in the other the heart only was abnormally situated in the right thorax.

The patient in the latter case was a child who presented all the phenomena of congenital heart disease but without any murmur.

#### *Myasthenia Gravis.*

At least one case of this rare and obscure disease has been the subject of investigation. The patient was a governess, aged 30 years, in whom muscular fatigue was apparent after every effort, however slight. Very little speaking caused the articulation to become defective and mumbling, mastication was impossible for more than a short time, and swallowing became difficult after the first few mouthfuls. The facial expression was stolid, and it seemed an effort to even raise the eyes. Rest temporarily restored power so that she was always at her best in the morning. In these cases the affected muscles behave very curiously to electrical currents. At first they react normally to faradism, but if the current is continued, they rapidly become exhausted and fail to respond ; if the current be withdrawn they soon recover and again react normally when the electrodes are re-applied. Contraction to the galvanic current is scarcely affected at all. From the characteristics of this myasthenic reaction, Dr. Harry Campbell, who investigated the case, suggested

that probably the muscles themselves were not fatigued, but that the motor end-organs were exhausted, and, therefore, faradism failed to stimulate them. He thought the exciting cause would prove to be a toxin with properties similar to curare.

#### *Erythromelalgia and Acroparæsthesia.*

Several cases of these curious forms of angio-neurotic disorder have been under our observation. The symptoms are subject to considerable variation, but the more important ones occur grouped together with sufficient uniformity to enable a case to be readily recognised. It is still a matter of dispute whether the condition depends upon a vaso-motor paralysis, or peripheral neuritis, or both. Though all the cases seen here were in women, the disorder is not confined to the female sex. Our patients were upwards of 45 years of age, and one or two of them were in the midst of the menopause. The leading features were pain, heat, loss of power, and a sense of fulness in the arms extending from the fingers to the elbows. The pain was always so accentuated after getting into bed at night that sleep was impossible. In some cases the skin over the hands and forearms was purplish in colour, in others unduly pale; one woman experienced copious sweating of the palms; several complained of numbness and prickling sensations in the fingers and forearms; and in one or two it was possible to demonstrate some impairment of common sensation. Every patient volunteered the information that after a washing-day her discomfort was intensified, so much so that one of them had come to look upon this part of her household duties as the sole cause of her misery.

The disease may commence in the toes, and affect the lower limbs in a similar way, but no example of such a distribution has yet come here.

Its etiology seems to be as obscure as its pathology, but many of its features bear a striking resemblance to Raynaud's Disease, with which, in all probability it is closely allied.

#### *Pulmonary Osteo-Arthropathy ("Marie's Malady").*

We mentioned in our last number (*see p. 146*) a very remarkable example of this condition which had been under observation, and

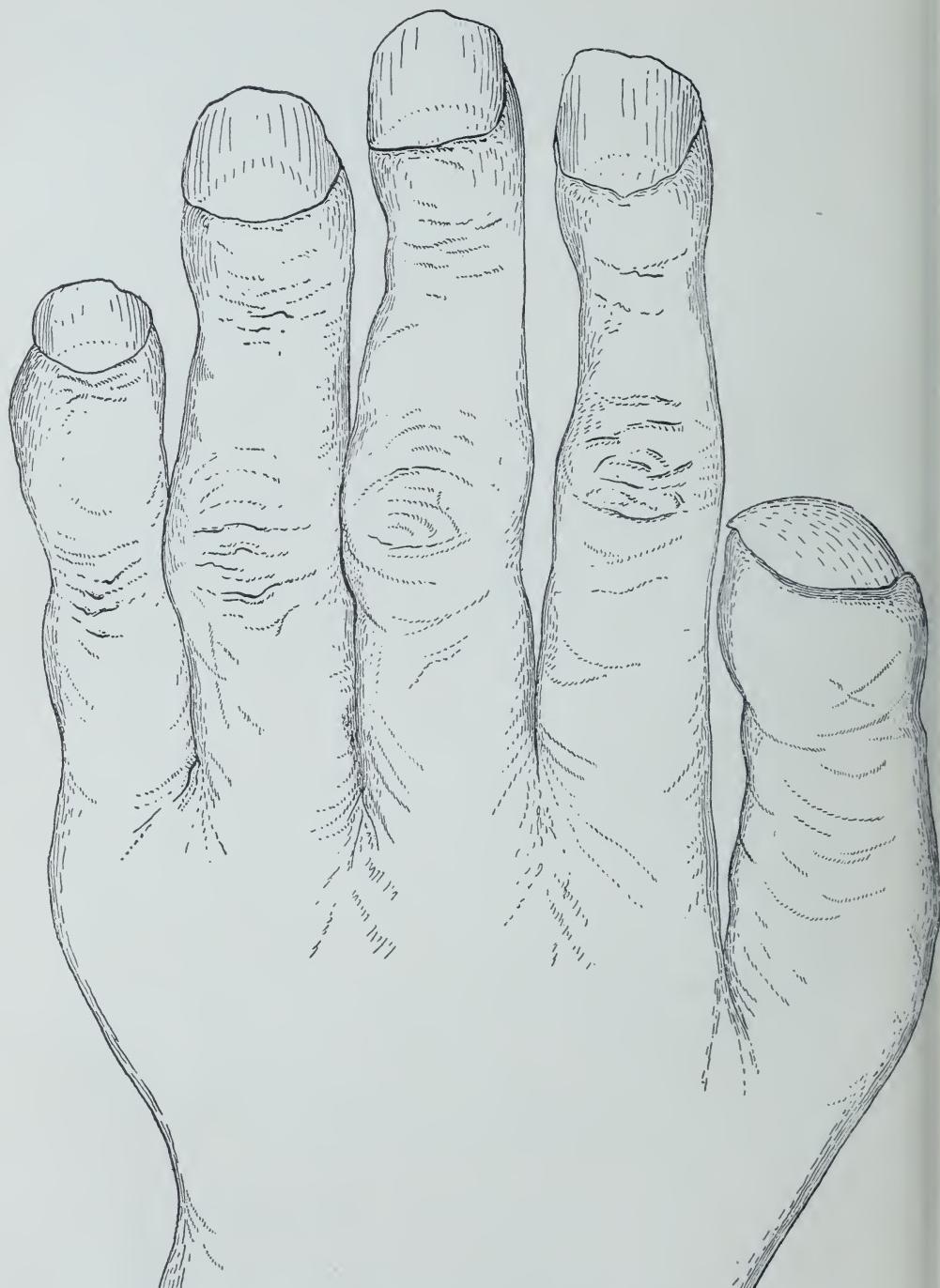


FIG I.—*The Nails in Pulmonary Disease.* (From Marie's Treatise.)

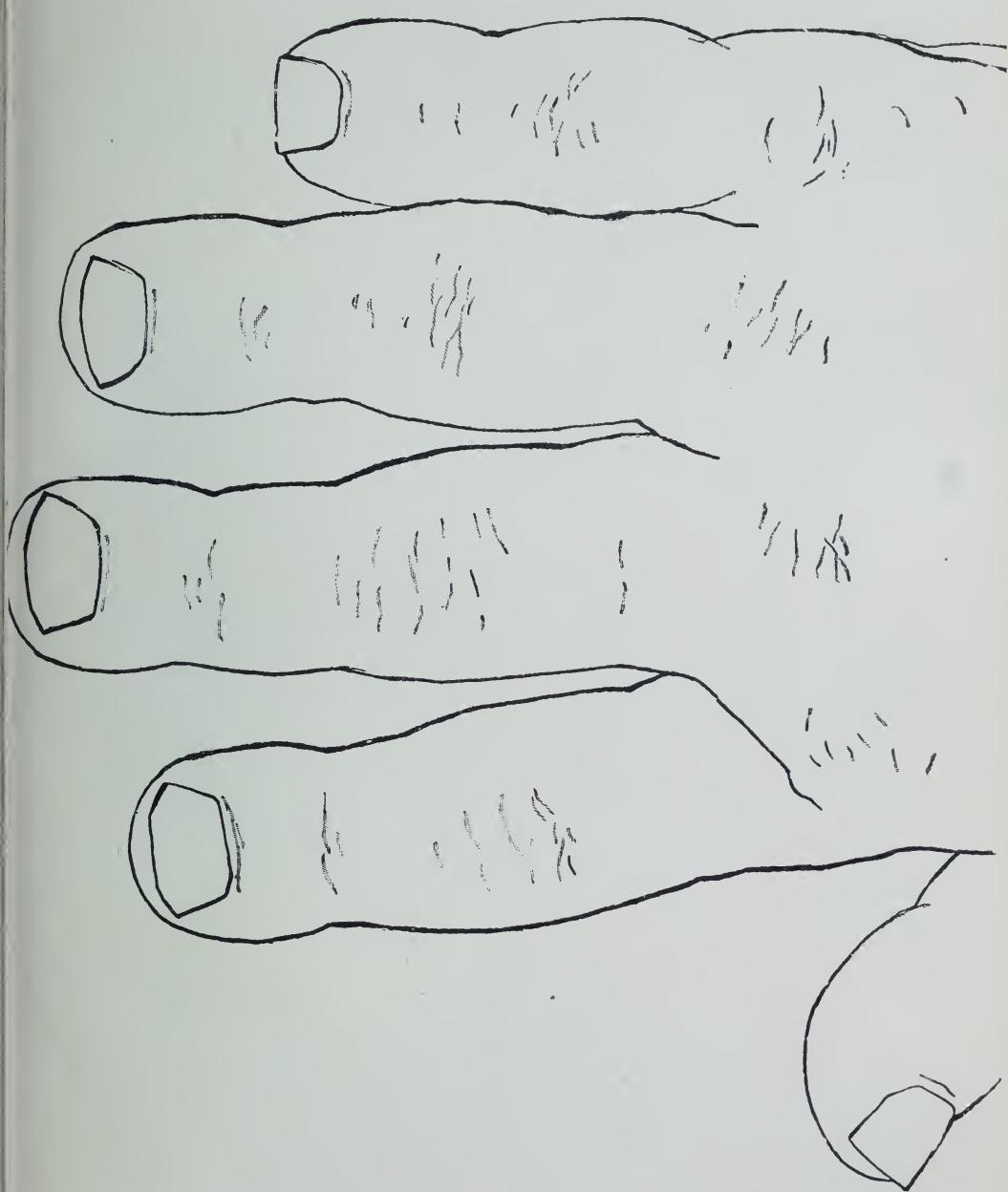


FIG. II.—*The Nails in Acromegaly.* (From Marie's Treatise.)

alluded to the differences presented by the finger nails in it, and in true acromegaly. We now, with the permission of the Council of the New Sydenham Society, reproduce from the translation of Marie's work, two woodcuts, which will convey much more clearly than words can, the features in which these differences consist. Fig. I. might serve as an illustration of our own case, for the conditions shown are no exaggerations of what were present in it.

### *The Special Courses of Lectures.*

These special courses of lectures have been a somewhat prominent feature of our work during the past few months, and if large attendances may be accepted as evidence of popularity, it would seem that their institution has met a felt want. Each course is limited to three lectures, but this is enough to allow the subject chosen to be dealt with by the lecturer in considerable detail and to afford him opportunity for full illustration of his remarks by demonstrations.

The practical application of surgery to individual organs and to special conditions of disease; the clinical examination of the blood; the administration of anaesthetics; the use of the Roentgen rays; the treatment and management of infectious fevers; bacteriological methods of investigation; the value of serumtherapy; and several courses in subjects specially connected with otology, ophthalmology, laryngology, dermatology, and gynaecology, sufficiently indicate the ground which these lectures have already covered and the scope which remains for future expansion in this direction of useful practical instruction.

### *Conclusion.*

Our recapitulation has much exceeded the length which we had designed for it, and it still leaves unnoticed many valuable contributions by members whose assistance in the Polyclinic work, did space permit, it would have been a pleasure to recognise. It must, however, here be brought to a close, to be resumed we trust when the next autumn vacation comes round. In the meantime we would beg earnestly to impress upon our readers the desirability, not only

of doing all in their power to enrich our Consultation Theatre with new cases of interest, but also of endeavouring to make complete the narratives of those already produced. We want, in order to serve the higher purposes of clinical investigation, not mere fragments of cases, but completed ones. It is one of the most valuable features in our organisation that it facilitates the production before us of the same patient as often as may seem desirable and also favours recurrence to the same topic until it has been fully elucidated. We hope that the new session will witness increase of zeal in these directions. It would be well if those members who have brought or sent cases for consultations would look back and see if any of them have subsequently offered features of interest. The Editor of the Journal will at all times be glad to receive information respecting such cases and will endeavour to utilise it. It is in the hope of serving these objects, and of making suggestions which our members may find useful, that these recapitulation notes have been compiled.

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## VISIT TO THE GUILDFORD AND WITLEY HOSPITALS.

IN preparation for our Excursion the following geological memoranda were prepared and were in the hands of all who took part in it. They were especially needed, as an important part of our proposed enquiry related to the prevalence of bronchocele on different geological formations.

*Geological Notes.*

The white chalk bed of the south-east of England is depressed into a broad, shallow valley, over the middle of which London is placed. This valley is crossed north to south, from near Hitchin to near Guildford. It is occupied chiefly by what is technically known as London clay, but which often consists of sand and gravel. At the Waterloo station, from which our excursion begins, the London clay is covered in by a layer of more recent deposit of alluvium, but on leaving the station a few miles, Wimbledon for instance, the line runs on the clay itself. It so continues till near Walton station. Here the clay becomes covered by a thick layer of sand (Bagshot sand) which gives to the neighbourhood of Oatlands Park and Weybridge their attractive scenery. Sections of this sand rock are well seen at the Weybridge station. Over all this district, as well as at London itself, the surface of the chalk lies deeply buried, but it is gradually rising nearer to the surface until at Woking it may be reached by well-diggers at no very great depth. Between Woking and Guildford it continues to rise until it not only reaches the surface but slants up as a sort of cliff, at places several hundred feet high. Near to the Guildford station white chalk is seen in cuttings on the line, and at the station itself a splendid cutting is exposed. This section has the great advantage over a mere cliff-facing (such as may be seen at the sea-shore), in that there is a lengthwise as well as a front exposure. The chalk here contains layers of flints, and these flints rule, as it were, lines across it. By their aid, in the side of the cutting by which the railroad enters the Guildford tunnel, the "dip" of the chalk may be easily appreciated. The lines slant downwards towards Woking, *i.e.*, the north, to soon lose themselves under the Eocene deposits, chiefly the "London clay."

A different fate awaits this chalk stratum to the south. It does not dip nor is it extended onwards, but is abruptly broken across, and presents to the south a steep escarpment at the foot of which strata older and lower than itself are exposed. You enter the Guildford Tunnel with high cliffs of white chalk on either side and fifty or sixty feet of chalk overhead; you come out of the tunnel with sand-rock both on the sides and overhead, and for many miles nothing more will be seen of the chalk. The strata upon which the line now travels southward consist of the Greensand series—upper and lower greensand with gault intervening, and the lower bedded on a thin layer of clay (Atherfield clay). Short tracts of these several strata are crossed repeatedly between Guildford and Petersfield. At the latter place the chalk is again encountered as a steep escarpment, after which it again dips towards Portsmouth, the Solent and the Isle of Wight, to constitute another valley or “basin” in all respects a repetition of that of London. In the middle of the Isle of Wight, from east to west, it rises to the surface as it does at Guildford, and a little further south it again breaks and exposes on the south of the island exactly the same strata that occur south of Guildford. Thus it will be seen that the plain of chalk has been thrown into two huge, but low, billows running east and west with troughs between them. In each case the top of the billow has been broken. In the northernmost a wide excavation has been formed which constitutes the Weald of Kent and Sussex—bounded by the north and the south Downs—while in the Isle of Wight the southern boundary of the excavation is lost in the sea. On the railway, after leaving the Guildford tunnel, we have to cross the end of the Weald, but only for a very short distance do we actually touch the clay of the Weald itself. Most of the distance is run on the lower greensand and it is this rock which is of chief interest to the medical observer. Although a dry, porous stratum, and rising frequently into high hills and broken into picturesque scenery, it is credited with being to some slight extent conducive to the development of bronchocele. Whether this be so or not is matter for enquiry. There can be no doubt that taken as a whole the district is a very healthy one. The Weald clay is unquestionably much more damp and cold than are the high sandstone hills, and it is highly probable that the latter are especially favourable places of

residence for rheumatic subjects and for all to whom a dry climate is important.

A few brief statements are needed to complete our account of the geology along the railway line. After escaping from the second of the two Guildford tunnels we emerge upon lower greensand, and crossing a narrow belt of it find exposed the Atherfield clay; a little further still this clay is denuded and that of the weald exposed. After a mile or so of weald we take the same strata in reverse order, Atherfield clay and then greensand. The whole distance from Guildford to Godalming is only a few miles, but in this short distance the exposed strata are changed eight times. Just before reaching Godalming station there is a valley of alluvium, through which a tributary of the Wey finds its course. From Godalming to Witley it is greensand, but immediately on leaving Witley station we descend over a narrow belt of Atherfield, and then run for four miles on the weald, making a gradual ascent upon it until close to Haslemere, when we are again on greensand.

The Atherfield clay is good for brickmaking, and whenever in this district the observer sees traces of a brickyard he may be almost sure that he is upon it. Wherever cowslips flourish there is assuredly clay of some kind, and wherever heath and the whortleberry grow there it is as certainly sand. The latter are abundant around Haslemere and there are no cowslips.

The bed of Atherfield clay which underlies the whole district south of Godalming is the means by which the water taken up by the extensive ranges of sand is retained. All the wells are sunk down to reach this stratum, and most of the springs which break out denote its junction with the sand above it. The water which it stores up is a remarkably pure water.

#### *Objects of Enquiry.*

At the Institutions visited it was proposed, in the first place, to see the patients and to investigate any cases which may present features of interest. Next it was intended to ask for information as to the diseases most prevalent in the locality, and under this heading the following special objects were mentioned in advance:—

- (1) The prevalence of bronchocele, with reference to the precise localities from which the cases come, and to the influence of family

predisposition. Questions may also be asked as to whether any of the cases are sufficiently severe to require treatment. Also whether cases of Graves's disease are often observed.

- (2) As to the prevalence of cancer.
  - (3) The prevalence of tuberculosis.
  - (4) The prevalence of syphilis and whether any cases of the inherited form are ever seen.
  - (5) The longevity of the district.
  - (6) The occurrence of local epidemics of diphtheria, typhoid or other maladies.
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## THE SURREY COUNTY HOSPITAL.

WE were received at the Guildford Hospital by most of the members of the Hospital Staff, amongst others Mr. Butler, Mr. Sells and Dr. Russell. The arrangements which had been made were excellent, a series of cases having been selected, of which full notes were produced. For these we were much indebted to the ability and zeal of Dr. Pritchard, the senior resident Medical Officer. Mr. Sells took the chair at a brief meeting in the Boardroom before our visit to the wards, and at a longer one after it, when the cases were discussed seriatim.

Amongst the more interesting of the cases which were shown us were the following :—

### *Cases of Rachitis.*

Two young children under Dr. Russell's care, in whom osteotomy on McEwen's method had been performed for knock-knee. In each it was associated with other signs of rickets. It seemed to be the impression that rickets is rather common in Guildford.

### *Operation for Perforating Ulcer of Stomach.*

A case of perforating ulcer of the stomach, for which a series of operations had been performed by Dr. Adamson. The young woman had suffered from symptoms denoting ulcer for many years, and finally had indications of perforation. She was at once sent into

the Hospital and an immediate operation performed. It was necessary to stitch the omentum over a partially-closed opening. Subsequently an abscess formed under the diaphragm, and the wound had to be opened and drained. Finally the diaphragm was perforated, and empyema resulted. A portion of rib was excised and the cavity drained. It now appeared likely that the patient's life would be saved by the measures which had been so perseveringly carried out.

*Abscess in Connection with Kidney following on Injury.*

A farm labourer, under the care of Mr. Sells, in whom after a severe fall and fracture of ribs a large abscess had formed above the kidney. It had been opened and drained, and fluid of urinous odour had been freely discharged. A feature somewhat remarkable, on the supposition that the kidney had been lacerated, was that there had never been blood in the urine.

*Thoracic Aneurism unattended by much Inconvenience.*

A case of thoracic aneurism, in which the tumour was bulging through the chest wall a little above the right nipple, had its subject in the person of a pensioned soldier, aged 41. The man had experienced so little inconvenience that he had almost declined treatment, and was attending as an out-patient. He had, however, a laryngeal cough and some pain in chest, with shortness of breath. He was Dr. Adamson's patient and was the subject of tabes. He had an ataxic gait, with lightning pains in legs, and entire absence of knee-jerks.

*Persistent Jaundice with Hobnail Liver.*

In the women's ward Dr. Gabb's patient was a middle-aged woman who was intensely jaundiced, and had been so for seven months. She was weak and had an indurated and nodular liver. She had had a slight transitory jaundice some years ago. Indulgence in alcohol was denied, but she had lived in a public house, being the wife of the proprietor. The diagnosis lay between malignant disease and advanced cirrhosis, and the consensus of opinion was much in favour of the latter. It was pointed out that it was just one of those cases in which, if the patient's life were prolonged, diffuse xanthoma might supervene. As yet there are no indications of it.

*Fracture of the Patella, from Direct Violence, in a Child.*

In the children's ward was a little boy of 4 who had been admitted with a fracture of his patella. His knee had been trodden on by another boy and a fragment had been broken off from one corner of the bone. It was very easily felt and quite loose. There was no transverse fracture.

*Diffuse Lipomatosis with Exceptional Concomitants.*

In this instance a case of unique interest was shown us by Dr. Russell. Its subject was a tall, well-made man of little more than 40; he was still florid and fairly well fleshed, but complained of great debility and breathlessness. He was prone to break out into perspiration, and his voice was reduced to a low whisper. His most conspicuous feature was the accumulation of fat on the back of his neck and about his jaws, exactly according to the usual arrangement in the diffuse lipomatosis of beer drinkers. Now Guildford is famed for its ales; the man had been employed as a public official and he admitted that he had taken his beer regularly. He thought that this tendency to accumulate fat on the back of his neck had been apparent for at least seven or eight years. Thus far, therefore, the case might be considered as one of the ordinary type, but there are other conditions to be described. The accumulation of fat was not limited to the regions named. The lowest part of his neck and the episternal notch was filled by a bulging and extremely soft mass of fat, there were symmetrically-placed "collops" of fat on the abdomen just below the navel, and another (central) at the pubes. In several positions—at the root of the neck and in the axillæ and above the elbows—there was some evidence of enlargement of the lymphatic glands. These it was difficult to appreciate because fat was accumulated about the same regions and was so firm and lumpy that it might easily be mistaken for glands. The two most peculiar features in the case were, however, a very considerable thickening of both clavicles and the loss of voice. All the soft structures by the side of the larynx were somewhat thickened so that it was difficult to examine the contour of the larynx itself externally, but the impression given to the finger was that the cartilaginous structures were themselves involved in hypertrophy.

The case is obviously one in which we must wait and watch its course before it can be fully understood. Dr. Russell proposes to make a laryngoscopic examination which may perhaps give important results. In the meantime it is intended to continue a course of arsenic. In its early stages the case had been suspected to be one of lymphadenoma, but in its present condition it is obvious that the phenomena of multiform lipomatosis preponderate, and taking into account the man's failure of strength, there seems reason to fear that the disease may run a quasi-malignant course.

#### THE PREVALENCE OF BRONCHOCELE.

In pursuance of the proposed object of making enquiries as to the supposed prevalence of bronchocele in the district, the following items of information were obtained.

All the Guildford surgeons concurred in the impression that the district around Pirbright<sup>1</sup> supplied most of the cases which they saw. All agreed that the cases were for the most part unimportant and that although they often resulted in chronic goitres it was very seldom that their subjects sought advice respecting them. The cases applying at the Hospital were exceedingly few, and no one could remember any case which necessitated an operation. Mr. Butler, one of the senior practitioners of Guildford and a gentleman of very large experience, stated his belief that the affection was now much less common than it had formerly been. In his early days he had, he said, known an elderly physician resident in Guildford (Dr. Bacon), who had enjoyed great repute in the treatment of bronchocele and who had had many patients (gratuitous) suffering from it. His remedy was lozenges of burnt sponge. It was now very rarely necessary to prescribe for the malady, but he (Mr. Butler) was still in the habit of occasionally using the lozenges. He related, as an illustration, the case of a young lady born and bred-up in the town of Guildford, who had developed a full neck and had, he thought, derived much benefit from the lozenges. Mr. Butler had known one case in which a young woman had died from compression of the trachea.

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<sup>1</sup> Pirbright is to the north of the chalk escarpment and on the Bagshot sand overlying the London clay.

He had not seen her until just before her death, but he obtained a *post-mortem* and found the trachea narrowed to a mere slit.

At Witley Dr. Baker related to us the case of a young woman who had a large thyroid and who experienced symptoms of tracheal compression after a fit of laughter and apparently from haemorrhage. She was sent up to the Gray's Inn Road Hospital and had part of the tumour removed by Mr. Berry. With the exception of this and one other, he had known of no cases attended by serious symptoms.<sup>1</sup> It was, however, in Dr. Baker's district that the only instance of epidemic prevalence of bronchocele, of which we could hear, had been observed. This had occurred in the King Edward's School (on sandstone) close to the Witley station. In this school it is rumoured that at one time at least one-third of the boys had bronchoceles. The school (a department of the Royal Bridewell Charities) has been in its present locality more than twenty years, and it is only recently that bronchocele has prevailed. Those were chiefly affected who had been longest in the school. None of the cases became serious, and recently the prevalence of it has very satisfactorily diminished independently, we believe, of any special precautionary measures. With this single exception, no one of whom enquiries were made had ever heard of the malady prevailing as an epidemic in any school, barrack or other public institution.

At Haslemere the evidence given by the medical men was of much the same tenor as that obtained at Witley and Guildford. They knew of many cases of chronic goitre amongst the villagers, chiefly women, but it was exceedingly infrequent for any of them to require treatment.

To sum up, then, it would seem that there is no reason whatever to suppose that bronchocele in the districts examined prevails more on the sandstone than on the chalk and clay, and that it is of no great prevalence anywhere. At the same time it is to be borne in mind that the only instance of a school epidemic has been met with on the sandstone.

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<sup>1</sup> Dr. Baker, in a letter received since our visit, has informed us that almost all the cases of bronchocele which he has seen have come from the Witley and Hambledon districts (lower greensand) and none from Chiddingfold (on the Wealden clay).

We enquired everywhere as to the frequency of Graves's disease. All our informants had met with a few cases, but there appeared no reason to suspect its unusual frequency.

#### TUBERCULOSIS AND SCROFULA.

As regards tuberculosis and scrofula, it was of course not possible to collect any very precise information. It is to be noted, however, that amongst the cases shown to us there was not a single one belonging to this category. We did not see either at Guildford or Hambledon a case of lupus, of gland-disease, or of joint-disease.<sup>1</sup> There appeared to be a general impression that the prevalence of such maladies, and also of pulmonary phthisis, had diminished. Respecting phthisis, the question was put to all our informants: Have you had any reason to connect the prevalence of phthisis with any single houses, streets, or villages? and by all a distinct negative was given. To the enquiry as to contagion an equally definite negative was given, excepting that several observers had known a husband and wife successively affected. In one instance a sister who had nursed a brother in phthisis became herself soon afterwards the subject of tubercular disease of one kidney. All our informants were inclined to think that they had seen tuberculosis prevail by inheritance in families. As a very remarkable exception to the tendency to hereditary transmission, however, Mr. Butler mentioned a case which had been under his observation in which a woman, who was the subject of phthisis at the time of her marriage, lived to become the mother of five children, the youngest of them born not very long before the mother's death, and none of whom had as yet shown any delicacy of health.

#### RHEUMATISM, GOUT AND RHEUMATIC GOUT.

We were not shown either at Guildford, or Hambledon, or Haslemere a single patient suffering from any of these.<sup>1</sup>

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<sup>1</sup> No one will infer, from the fact that such cases were not shown us, that none such could have been produced; but it is fair to assume that there were none of urgency or presenting peculiar features.

## THE HAMBLEDON UNION INFIRMARY (WITLEY).

THE Hambledon Union comprises a large, thinly-populated rural district of great natural beauty, and most of it under conditions likely to be conducive to good health and longevity.<sup>1</sup> The greater part of it is geologically on the Greensand formation, but a portion is on Wealden clay. The Workhouse and the Infirmary which adjoins it are placed on the slope of a sand-range, at a considerable elevation, with magnificent views over the surrounding country, and well protected by large pine woods. No position could be better chosen for such institutions. Into their wards must gravitate all the disabled poor of the district whose relatives are unable to support them.

<sup>1</sup> Dr. Baker kindly supplied us with the following statistical statements which may prove of interest in the future for comparison with those of similar institutions:—

Present number of inmates of house	...	...	...	83
" " infirmary	...	...	...	42
				—
Total	...	...	...	125
Of these ...	39	are between 60 and 70		
37	"	70	"	80
23	"	80	"	90
1	is over	90	(93)	

Average at death, Michaelmas 1897 to Michaelmas 1898	...	65 years
"	1898	1899 ... 74½ ..
"	1899	1900 ... 72 ..
"	1900	1901 ... 66 ..

Of deaths during 4 years, 36 were due to old age and general feebleness (some more or less demented; some partially paralysed, &c.).

- 4 due to phthisis (3 males, aged 55, 58, 69; 1 female, aged 25).
- 1 " alcoholism and cirrhosis.
- 5 " acute bronchitis.
- 2 " acute pneumonia.
- 4 " severe heart disease.
- 1 " erysipelas.
- 3 " acute form of Bright's disease.
- 1 " diabetes (boy, aged 16) (with phthisis).
- 1 " status epilepticus.
- 1 " sarcoma of tonsil (male, aged 61).
- 1 " cancer of liver (female, aged 46).
- 1 " cancer of bowel (male, aged 66).
- 1 " cancer of stomach (female, aged 57).
- 1 " cancer of rectum (male, aged 59).

Our visit was to the Infirmary alone, but we had the advantage of statistical information as to the Workhouse also, which was kindly furnished by Dr. Baker, who is the medical officer to both. Our object in selecting this Infirmary for a visit was to obtain information as to the character of the diseases most prevalent in the district, and as to the general longevity, with also some hope that we might possibly be shown individual cases of sufficient interest to be worthy of investigation, and perhaps of record. In none of these directions were we disappointed. About an hour and a half were spent in the Infirmary, and Dr. Baker, who conducted our party round it, supplied us liberally with all the information we were in quest of.

Some of the negative observations were possibly as important as the more positive ones. We were not shown a single example of mammary cancer and were told that there was not one in the house. Nor could a single case of bronchocele be produced, although it is alleged to be endemic in parts of the district. Yet more remarkable, perhaps, if we bear in mind the character of the Institution as a home for the incurable and senile, we did not see a single example of any form of chronic rheumatism, gout or rheumatic gout. Nor were we shown any case of incurable skin disease. Whether or not this last negation may be placed to the credit of the advanced dermatological knowledge of the present day, or to some other factor, we must not attempt to decide, but it is of interest to note that a similar record applies to our experience at the Guildford Hospital.

Amongst the more instructive of the cases shown to us were :—

#### *Several Cases of Cancer.*

In one of these Dr. Baker had amputated at the wrist for epithelioma of the hand in an old man of 85, who is now, after a two years' interval, without gland disease or other sign of return. In another, a fine, tall, old man (76) who had been a gamekeeper, had had the left half of his tongue removed (by Sir Frederick Treves in the London Hospital) eleven years ago and had experienced no return. In the interval, however, he had had his right mammary gland, together with a gland from the armpit, excised (by Mr. Sydney Jones in St. Thomas's Hospital). This was in 1895. As some one

may possibly be interested in looking up the hospital notes of this case, we give the man's name—Inwood. He assured us that he did not know of any family history implying proclivity to cancer. It will be seen that six years have elapsed since the second operation. There has been no sign of return in either case.

An old man (68), in whom the right parotid was involved in a large cancerous growth which had recently ulcerated, averred that he had had a movable lump in the side of his face for twenty years, and that it was only within the last twelve months that serious developments had taken place. His evidence was not, however, very lucidly given, and he spoke indistinctly, as his facial nerve was involved and its muscles paralysed.

In another case an old man had a one-sided mass under the sterno-mastoid as large as a fist and as hard as a stone. It extended from a little below the angle of the jaw to the clavicle. It was at once pointed out that it was not like the "potato tumour" in which we have recently been interested, in that it did not lie under the upper part of the muscle and was placed vertically instead of obliquely. These features pointed to some primary disease in the man's throat, and although he utterly denied any throat symptoms and said that he could swallow well, he confirmed the suspicion by telling us that he had had pain in his ear and side of head before the swelling in the neck had appeared, and that he had become deaf. On careful examination a primary epithelial ulceration involving the parts about the Eustachian tube was found and all obscurity as to diagnosis vanished.

#### *A Case of Obscure Cerebral Disease.*

Unfortunately we had in our party no neurological specialist, but several of us felt interest in a cursory examination of a man who presented somewhat obscure symptoms of cerebral disease. Dr. Theodore Williams and others examined him, but as he was partially aphasic it was difficult to get a clear account of the facts. He was a discharged soldier of intemperate habits, and who had possibly had syphilis. He was confined to bed and could not walk without assistance, but had no actual paralysis. His hand-grasp at first feeble became firm after prolonged effort. His tongue pointed to the right, and his patellar reflex was more increased on the right,

and his right hand was supposed to be weaker than the left. His pupils were of equal size and moderately active. His age was 50.<sup>1</sup>

#### *Almost a Centenarian.*

In one of the women's wards we saw a bedridden old lady, deaf, and of much wrinkled features, whose age we were assured could be vouched for as 96. She had been a nurse.

#### *Bronchocele.*

Dr. Baker told us that although he knew that chronic bronchoceles were not uncommon in certain parts of his district, he was very rarely indeed consulted about them, and scarcely ever had their subjects in the Infirmary. He knew of two cases from the district in which operations had been done. In one of these a married woman, who came from Suffolk, had the disease in an early stage before she came into Surrey. The tumour steadily increased afterwards, during her child-bearing period, and finally excision of one half of the gland was performed by Mr. Butlin, in St. Bartholomew's Hospital. In the other, which we have mentioned at page 201, a young woman, a native of Witley, had an operation by Mr. Berry, in the Gray's Inn Road Hospital. These were the only cases which Dr. Baker had known in which the need for an operation had been in the least indicated.

#### *Sporadic Diphtheria, &c.*

Dr. Baker related to us some remarkable instances of the sporadic and wholly unexplained occurrence of diphtheria in isolated cottages. In some of these, several children in the family had suffered, but in all, epidemic spreading had been prevented. The cottagers had, he said, a bad habit of accumulating in tubs, near to their doors, refuse of food intended to serve as pigs'-meat. When by chance there was no pig in the sty, these tubs became very offensive by decomposition, and might, he thought, be the sources of disease.

<sup>1</sup> We give these facts not with the idea that they can be of clinical use in their present form and stage, but because it is very possible that they may lead to further investigation. The case is one in which an autopsy may probably be obtained, and in these days of motor cars and bicycles, it is possible that some investigator may be zealous enough to devote a half holiday to a visit to Witley and an examination of the case. Should he do so, we doubt not that on communication with Dr. Baker he will be accorded every facility.

## REVIEWS AND NOTICES OF BOOKS.

THE PATHOLOGY AND SURGICAL TREATMENT OF TUMOURS. By N. Senn, M.D. Pp. 718. Saunders, Philadelphia. Price 21s.

The Chicago professor to whose pen we are indebted for the large book before us has achieved repute as a talented surgeon and industrious author. The present work is well printed and well illustrated, and it teems with citations of opinion and statements of fact. Yet there is scarcely a page of it which does not more or less excite the critic to hostile comment. Its author has read largely—perhaps too largely—but he has not well digested the mass of material which he has collected. There is a certain crudity and lack of clinical completeness and finish about all his pictures of disease. Yet it is a book which no one can read without being instructed, and from which, if he does not obtain a perfectly lucid and correct statement of the doctrines of the day, he will, at any rate, find most of them referred to. He will feel sure that he is reading the pages of a practical surgeon, but at the same time he will, if we mistake not, regret that they should have been put together with so much evidence of hurry. A few examples of what we mean may be taken from the chapter on cancer :—

“Carcinoma is an infiltrating tumour and has abrupt, well-defined margins.” Surely there is an approach to a contradiction in terms here, nor is either the first or the second half of the statement universally consistent with facts.

We are further told that “In rapidly-growing tumours particular pains should be taken to ascertain a possible source of infection.” Why should we seek the source of infection more zealously in rapidly growing tumours than in those growing slowly, and how, in either case, are we to set about the undertaking?

Respecting the local prevalence of cancer Dr. Senn tells us—“There is no doubt that malignant tumours are unequally distributed over the world. . . . Heredity unquestionably plays an important part in imparting to these tumours in some localities an endemic character. *The accumulation of many generations in particular localities would naturally increase the number of its*

*victims.*" Were it possible no doubt it would, but as far as our knowledge goes the only localities in which many generations accumulate are not prone to supply victims.

The paragraph on p. 411 respecting *lipoma of the eyelids* is a puzzle. We are told that "the fibroma lipomatodes of Virchow, the 'xanthoma' which is usually found upon the eyelids, appears as yellowish or brown spots"; next that "the tumour is sometimes quite diffuse and large"; and lastly that "xanthoma may occur as a primary lesion on other parts of the body, more especially where the skin is exposed to repeated injuries." We can only say that if these statements are generally true of xanthoma in Chicago it must present very great differences from what we see in London.

We should be sorry to appear unduly critical, but it would be easy to accumulate enigmatical sentences of like character to those quoted. Yet with all its blemishes, and they are many, it remains the fact that the work is one from which much information may be obtained.

STUDIES IN HUMAN AND COMPARATIVE PATHOLOGY. By Woods Hutchinson, A.M., M.D., *Professor of Comparative Pathology in the University of Buffalo.* Pp. 340. London: H. J. Glaisher.

This is a book which everyone should read, and which all will read with pleasure. It is no dry manual of the diseases of the lower animals, but a light-handed sketch by one quite competent to have gone into detail, of their relations to those of man as illustrated by modern investigations in embryology and histology. The opinions advanced are well up to date, or indeed, in some matters, we might perhaps say well ahead, and they are often in a high degree suggestive. The author avows that "his effort has been rather to stimulate thought and investigation in others than to advance dogmatic conclusions based upon any researches of his own." Yet every page shows that such researches have been made, and that the pen is in a hand well familiar with the scalpel.

### MUSEUM NOTES.

WE have received through Dr. Michie from the Executors of the late Major A. F. Ferguson who practised in India, a valuable collection of Calculi, accompanied in most instances with some details of the case. For these and for the following the Museum Committee offers its best thanks.

In response to a request for specimens of calculi from India, we have received an interesting and valuable collection from Dr. R. K. Das Gupta, I.M.S., of Durbhangha, Bengal. They are all either uric acid or oxalates, or mixed. They have been placed in the Museum, and our best thanks are offered to the donor. We shall be glad to receive more specimens of unbroken calculi from any source.

### ILLUSTRATIONS OF SYPHILITIC KERATITIS.

We have placed in the series illustrating Diseases of the Eye a plate which is of very considerable historical interest. The disease, which is now universally recognised as "syphilitic keratitis" (interstitial or parenchymatous keratitis) was well known in all its peculiarities to our forefathers. They named it "Scrofulous Corneitis," but they knew well that in clinical history it differed much from all other forms of scrofulous ophthalmies, such as the phlyctenular, the scrofulous ulcer, &c. The plate to which we refer is devoted entirely to the illustration of this special "Scrofulous Corneitis." It contains twelve well-executed figures, coloured, and although the diagnosis may be doubted in figs. 6, 7, and 8, the others display very characteristic conditions. It is taken from a short monograph on this special malady by Professor Froreip, of Jena. The descriptions are in Latin, and from them we condense the following account, introducing where needful our own comments :—

Description of a plate published in 1830 by Professor Froreip, of Jena, with an Essay entitled *DISSERTATIO MEDICA DE CORNEITIDE SCROFULOSA.*

Figure I. is the left eye of a girl who is stated to have been ill developed, 16 years of age. The disease had been present five months. It shows a typical condition of ground glass cornea with "salmon patches."

Figure II. is described as the more chronic form of scrofulous corneitis, in a girl aged 16. Like the preceding it shows the ground glass condition with salmon patches. In the text complete but slow recovery is confidently predicted.

Figure III. from a girl of 8, is described as showing the more chronic form of scrofulous corneitis.

Figure IV. from a young man aged 20, who, like the subject of the preceding drawing, is described as being florid and in good health. The cornea shows the ground glass condition.

Figure V. the same eye seen in profile.

Figure VI. the eye of a young man of 20, who had suffered from "scrofula."

Figure VII. the eye of a woman aged 26.

Figure VIII. from the same patient. The conditions shown in these eyes are those of relapsing cyclitis rather than of true keratitis. Staphyloma of the ciliary region is described in the text.

Figure IX. is the left eye of a man aged 30, with conditions of the same kind as those shown in the two preceding.

Figure X. illustrates the sequelae of scrofulous corneitis. A central leucoma of the cornea is depicted. The patient, a woman of 52 years of age, had suffered from a chronic attack of "strumous corneitis" two years previously. Her right eye had been lost, and the condition of the left is shown in the illustration.

Figure XI. the right eye of a woman of 20, who had passed through an attack of scrofulous corneitis in her fifteenth year.

Figure XII. is given to show the slight condition of haze which frequently remains after scrofulous corneitis, "*qui post faustissimum corneitidis scrofulosæ decursum semper inveniri potest!*"

The illustrations fully prove that Froriep had recognised all the clinical peculiarities of the disease now known as syphilitic keratitis.

#### PORTRAIT ILLUSTRATING THE COINCIDENT OCCURRENCE OF DIFFERENT ERUPTIONS.

It is of interest to note the coincident occurrence in the same patient, of eruptions which have acquired different names and are supposed to be specially distinct.

An instance of this occurs in Kaposi's Tafel 35 which represents "*Chloasma in mare cachecticorum*" together with a large glandular swelling under the jaw, and "*Lichen scrofulosorum regionis clavicularis et trunci.*" The portrait shows extensive pigmentation in patches and spots on the cheeks, nose, upper lip, and forehead of a young man. The pigmentation is far greater than in common freckles, and we may note that Kaposi calls it chloasma and not lentigo. The precise meaning of the word chloasma is not given. Probably lentigo would have been quite equally correct. Many observers have, no doubt, noted that freckles occur in the scrofulous in great plenty. Kaposi's portrait would appear to confirm this opinion, and the three different affections which occur together give to each other mutual support in the direction of their all being manifestations of tuberculosis. The freckles may have been the

expression taken by lichen scrofulosorum on the face. The patches of the latter which are seen on the neck are to some extent pigmented. The man is not red-haired, as are most of those in whom freckles are abundant.

#### PORTRAITS OF NIPPLE CANCER—PAGET'S MALADY.

The group of portraits illustrating nipple cancer include with others, the following :—

(i.) A coloured drawing by Burgess from a patient under Mr. Hutchinson's care many years ago, showing an ulcerated surface as large as the outspread hand. The clean, florid, granular surface and the polycyclical border are well shown. The disease had been in progress some years, and the patient was an elderly woman. The conditions are most characteristic.

(ii.) The portrait taken from Pringle's St. Louis Atlas. It shows exactly the same conditions as those described above, but the extent involved is not so large, and the granular surface is coarser. There is also a deeper ulcer near the nipple itself. The patient in this case was a woman of 35, in whom the disease had commenced four years previously by retraction of the nipple with discharge from it. There had been stabbing and pricking pain, as if from pins, but no itching. Some years previously, a lump the size of a pigeon's egg had been detected under the nipple in the other breast, but it had entirely disappeared. The patient died unexpectedly of cerebral haemorrhage in 1889, seven years after the commencement of the cancer. Erosion and caustics had been used, and there had never been any signs of gland disease.

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#### CORRESPONDENCE AND ANSWERS.

Arbuthnot, on "Rickets," writes : "They may be allowed a moderate quantity of wine. I knew a rickety child cured by a very great indulgence of fermented liquors ; but it is not an experiment that I should advise" (p. 417).

\* \* \*

A HINT FOR THE CORPULENT.—"Fat people ought to avoid oily nourishment ; but soups, which consist of oil and salt, are proper, because they are resolvent."—ARBUTHNOT on "Aliments," p. 303.

\* \* \*

INLAND INFLUENCE OF THE SEA.—An account of the influence of a "salt-storm" from the sea upon vegetation fifty to seventy miles inland will be found in the seventh volume of the *Linnæan Society's Transactions*. In that case windows at

Hounslow and Mill Hill were encrusted with salt; the leaves of many evergreens were much injured. The storm occurred in January, 1803, and prevailed several days. A similar phenomenon was observed fifteen years ago at Haslemere, which is nearly thirty miles in a direct line from the sea. It has also often been known at Crowborough Beacon, near Tunbridge Wells.

\* \* \*

**GOUT IN KAFFIRS.**—In "Herrman's History of Rhodesia" (just published) it is stated that Dr. Jameson had treated Lobengula for gout. Can any of our readers give further information as to the occurrence of true gout in Kaffirs?

\* \* \*

**LEPROSY IN CYPRUS; A RUTHLESS ORDER.**—There is a tradition in Cyprus that leprosy was first introduced into the island about three hundred years ago, and that a certain monastery (Troöditissa) was its cradle. Outside the Famagusta gate of Nicosia a leper camp was formed of huts, in which the poor creatures, who subsisted by begging, resided. Early in the present century the Pasha ordered that they should all be destroyed, and the huts demolished. This order was not carried out. The lepers were instead deported to a farm two miles from the town.

\* \* \*

A MEMBER sends the following extract from a medical journal: "Little is known regarding the cause of leprosy, but M. Lortet points out the interesting fact that the lepers in Syria are fellahs, that is, Mussulman or Christian farmers, whose diet is notably poor, consisting of innutritious vegetables like lentils, with never any meat. The Israelites, and in general the inhabitants of the towns, however unsalubrious the surroundings of the latter, are exempt from leprosy. Ichthyophagy, as a cause of the disease, is rejected by M. Lortet, his Syrian fellahs having for the most part no fish to eat."—Editorial, *Boston Med. & Surg. Journ.*, April 10, 1884.

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**SHAKESPEARE'S KNOWLEDGE OF SYPHILIS.**—In our last number (p. 158) the question was asked whether Shakespeare referred to the osteoscopic pains so common in syphilis when he wrote "the bone-ache is the curse dependant on those that war for a placket." The quotation is not, as the question stated, from *The Winter's Tale*. It is found in *Troilus and Cressida*, act ii., scene 3, and reads, in some editions, "the Neapolitan bone-ache." In view of the spread of syphilis in Europe credited to the siege of Naples, this makes the reference more significant. A parallel passage is found in *Othello*, act iii., scene 1, where the clown, in finding fault with the wind instruments of the musicians, is made to say, "Why, masters, have your instruments been in Naples, that they speak i' the nose thus?" Further references to the effects of syphilis on the bones may be traced in the lines—

"Consumptions sow  
In hollow bones of men; strike their sharp shins  
And mar men's spurring. . . . .  
. . . . . down with the nose  
Down with it flat; take the bridge quite away."

*Timon of Athens*, iv., 3.

And in

"Thy bones are hollow; impiety has made a feast of thee."

*Measure for Measure*, i., 2.

The whole subject of syphilis in Shakespeare's plays will be found illustrated in "Medicine in Shakespeare," by the late Dr. Jno. Moyes, published by Maclehose, Glasgow.

# THE POLYCLINIC

BEING THE  
JOURNAL OF THE MEDICAL GRADUATES'  
COLLEGE, LONDON.

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VOL. V., No. 5.—NOVEMBER, 1901.

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## THE DOCTRINE OF NORMAL PARASITES.

A “NORMAL PARASITE” is one which causes to its host no injury. Perhaps the term “Harmless parasite” would be better, for it is scarcely meant by the term “normal” that the guest is in any sense necessary to the health of its entertainer. In the vegetable kingdom, and in some instances amongst the lower animals, it would almost seem that the parasite is normal in the latter sense, but probably there is no proof of such relationship between the two in the higher animals. We have nothing analogous to a Lichen, in which a fungus and an alga live in perpetual and united companionship, and produce a new and complex organisation which differs from both but yet is not a hybrid. Nor have we anything which approaches the condition of that sea-anemone, the soft body of which is always green from the presence in its substance of the cells of a green seaweed. If any condition of normal parasitism of that type occurs in the tissues of the higher animals—it is quite possible that it may—it has yet to be discovered. The researches of bacteriologists have, however, made it quite certain that living organisms may habitually infest the human subject without producing any ill results. They infest chiefly the mucous membranes, but there is nothing to discredit the suspicion that they may be found in more deeply placed parts. Some of them appear to be

quite and always harmless, but others which are for the most part innocent may, upon occasion, manifest virulent properties. Of these latter the Pneumococcus (Franckel's diplococcus), and the *Bacillus coli communis* are good examples. The pneumococcus is present in the nasal cavities from year to year in those who appear quite well, but it may at times cause pneumonia or fatal peritonitis.

It is obvious that we have here two vistas of most important speculation and investigation opened before us. In the first place we have to ask, respecting other parasites hitherto deemed always hurtful, whether they may not have their periods of innocence, and respecting all we have to seek with diligence as to the kind of influences under which their aptitudes change and they become virulent. The bacillus of tuberculosis, for instance—may it become under favourable conditions a normal or harmless parasite? So also of that of leprosy. Of the latter we know from unquestionable evidence that a man may have shown no evidences whatever of its presence for twelve or twenty years from the probable date of its reception. Of tuberculosis we know that after a temporary manifestation of activity it may, so to speak, go to sleep for thirty years and at the end of that time wake up into renewed activity in the self-same structure which was its first home. It is in cases of cured lupus chiefly that we witness this astonishing feat of latency. Is it fair to say that during these long intervening periods the parasite has been present as a "normal" one? If we might adopt this hypothesis of possible "normality" it would clear up many of the difficult questions in the clinical history of tuberculosis. Most especially it would help us to interpret the phenomena of heredity. Nor would it in this instance be difficult to assign explanations of the assumption of activity, for the facts have been abundantly discussed under the name of "predisposing influences." We have been assured, for instance, that an attack of measles renders its subject prone to receive the infection of tuberculosis; it may, perhaps, be that it excites to activity a "normal" parasite already present. A very interesting problem is also suggested as to whether certain ingredients in food may be the means of thus stimulating normal parasites and transforming them into very injurious agents.

The topic with which we are dealing is one of far-reaching importance. Our knowledge of the life history of these minute

forms of vegetable or protozoic life is as yet in its infancy, and we must not assume that we know everything respecting the conditions under which they can exist.

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### THE THERAPEUTICS OF EXOPHTHALMIC GOITRE.

THE treatment of Graves' Disease may be said to be in a state of chaos. No single principle has been well established. From time to time various drugs have been brought forward, and more or less strongly praised. They have, however, been very various in their modes of action, and in some instances even of antagonistic properties. Thus aconite, arsenic, digitalis, steel, bromides, and lastly thyroid extract have had their advocates, and have each in turn been accused of being prejudicial rather than otherwise. Nor has surgery been idle, and two procedures, which considering their serious nature, and the fact that the disease is in the main functional and susceptible in a majority of cases of spontaneous recovery, may almost be called barbarous, have been extensively practised. On the hypothesis that the phenomena are those of a vaso-neurosis, it has been thought warrantable to take away an important ganglion of the sympathetic system, with but the very vaguest notion as to what effect such a procedure might have. On the supposition that the disease is caused by excess of function on the part of the thyroid gland, large portions of it, or even the whole, have been repeatedly excised. This latter operation has had a long list of fatal cases, and when we remember that the contrary practice of giving thyroid extract has appeared to be useful in many cases, and that the operation, even when the patient survives, involves some risk of myxoëdema, there is great reason for satisfaction that both it and its competitor have fallen into discredit and disuse.

The confusion of opinions as to the value of different drugs is no more than ought to be expected from the fact that we are still far from understanding the real nature of this curious malady. That its chief phenomena are those of a vascular neurosis may be recognised, but there remains the all important question—What causes the neurosis? That it is more than a merely local disease seems

almost certain. The common forms of bronchocele, whether sporadic, endemic, or epidemic, are not attended by proptosis or by vascular disturbance, and it was ascertained very early in the history of the malady that iodine and its salts, the specifics for bronchocele, usually aggravated its phenomena. They have, we believe, no advocates at the present day, though it is possible that there are points in reference to dosage and concomitants which may well be worthy of reconsideration. A direction of enquiry which might perhaps be fruitful is that of taking note of slight conditions tending towards Graves' disease, but in which it is never fully declared. These are probably far more numerous than are those which are definitely diagnosed, and if we could have full information as to the conditions under which they are originated and decline, it might help us in the treatment of the more severe ones. It might not improbably be found true that they are most common in young adults, and that in the female sex they are associated either with pregnancy, parturition, or amenorrhoea. The fact that in many cases of this class the symptoms, threatening for a time, pass away entirely, may help us to the more distinct recognition that in all, even the most severe, if the patient can be kept alive, there is a tendency to spontaneous recovery. We have, indeed, no cases in which the phenomena persist indefinitely, although some of their local consequences may be permanent. The further observation is also probably well founded, that when a patient has once passed through a severe attack there is no liability to recurrence. Thus, then, it may be described as a transitory neurosis, severe and dangerous for a time, but certain to pass away. A knowledge of this should lead us to be very careful to do nothing to impede the spontaneous tendency to recovery. No drug should be pushed to an injurious extent, and of all, large doses should be avoided unless it is quite certain that they are suiting. Our remedies should be those which, if they do no good, will at any rate do no hurt. Even the ordinary tonics such as quinine and nux vomica should be used cautiously and in small doses. One measure, however, appears to be indicated in all cases, and before all others. We allude to a complete change in the patient's residence and surroundings. We do not know what may have been either the predisposing or the exciting causes, but at any rate it will be wise to substitute for the

influences under which the disease has taken its mysterious origin others as widely different as possible. The patient should as a rule not be taken into a hospital, but sent into the country to live an out-of-door life and engage in such exercise, or even labour, as may be possible. The drinking water should be changed, and if enquiry can detect any peculiarities in diet they should be abandoned. If the disease have begun inland the patient should be sent to the sea, and if at the sea to a mountain sanatorium.

It is a question of great clinical interest whether the common parenchymatous goitre is in any sort of relationship with Graves' disease. Without doubt the enlargement of the gland which occurs in the latter is of the parenchymatous type, but it is equally undoubted that in a large majority of cases of the ordinary form of bronchocele there is no tendency to proptosis and none of the nervous phenomena which usually attend Graves' disease. No one will doubt that in the latter, if there be any relationship whatever, a very important and influential factor is superadded. Still it remains as an interesting subject for enquiry whether cases of Graves' malady are disproportionately frequent in goitrous districts, and whether during the onset of common goitre, such, for instance, as occurs in epidemics, any of the patients show tendency to nervous disturbance or to proptosis. Are cases of Graves' disease met with in those countries, Sweden and Norway for instance, which are asserted to be wholly exempt from goitre.

We may suitably here append the following memoranda written after perusal of some interesting papers recently published in the *British Medical Journal* :—

#### MEMORANDA AS TO THE PATHOGENETIC INFLUENCE OF THE THYROID AND PARATHYROID GLANDS.

The term *Athyroidea* is applicable to the condition which results from removal of the thyroid gland or its destruction by disease. It may be actual or relative, *i.e.*, functional. *Aparathyroidea* is the term applicable to the results of removal of the parathyroids.

Myxoedema follows removal of the thyroid itself, Graves' disease the removal of the parathyroids.

Thyroidism and hyper-thyroidation are terms applicable to excess of function of the thyroid gland or the administration of its extract.

The hyper-thyroidation theory of Graves' disease is now abandoned (Gley), and it is even alleged that in some cases the use of thyroid extract is beneficial.

It is now alleged that Graves' disease and myxœdema do not stand in such strong contrast with each other as was at one time supposed. In acute myxœdema in animals, as produced by excision of the thyroids, some of the symptoms of Graves' disease are also present.

No condition resembling Graves' disease is ever produced by the administration of thyroid extract either in man or animals.

The active element formed in the thyroids is the colloid substance and in this is contained an iodo-proteid compound.

In association with the thyroid gland are two pairs of glandules known as the parathyroids. These glandules are certainly in functional association with the thyroid itself, and the integrity of the one is necessary to the healthy action of the other.

It is supposed that myxœdema is the result of diminished thyroid secretion and Graves' disease of that of the parathyroids but the interaction of these glands is probably complex. In Graves' disease the colloid formed by the thyroid is not of normal composition (Edmunds).

In Graves' disease there is a diminution of the iodo-proteid, Gley suggests that there is only one-tenth the normal amount.

The extract of the parathyroids is not as yet in the London market, but it has been made the subject of experiments and with the result, it is said, that it is not remedial in myxœdema.

In connection with the pathology of the thyroid gland we may enumerate the following affections :—

- Parenchymatous bronchoceles, sporadic.
- Parenchymatous bronchoceles, epidemic.
- Parenchymatous bronchoceles, endemic.
- Sexual bronchoceles. The bronchoceles of adolescents, &c. (often only transitory).
- Exophthalmic goitre (Graves' disease).
- Chronic or persistent bronchocele, including cysts and adenoceles.
- Malignant bronchoceles.
- Myxœdema, the result of athyroidea.
- Cretinism, a result of infantile athyroidea.

## THE DECLINE OF PULMONARY PHTHISIS.

STATISTICIANS assure us that during the last forty years the mortality from consumption in England has diminished something like fifty per cent. Although we may entertain some little misgiving as to the absolute truth of this statement, and may fear that it ought to be discounted to some extent on account of fallacies, yet it is in a general way in accord with prevailing experience, and may be thankfully accepted as in the main true. There can be no difference of opinion as to its having resulted from influences which came into operation quite independently of the discovery of the bacillus. The influence of the doctrines which have sprung from Koch's discovery are scarcely even as yet appreciably felt, and they certainly had no force even so recently as ten years ago. It becomes, therefore, of the utmost interest to try to ascertain what have been the real causes which have produced this very satisfactory result. Not only is the diminution of deaths from pulmonary phthisis in itself a great gain, but it implies, without doubt, a much larger one in other directions. With phthisis go a number of other affections more or less definitely tuberculous, including many diseases of the eye, skin, joints, &c., usually classed as scrofula. In engaging in our enquiry we may note, to begin with, that long before the discovery of the bacillus physicians were well aware of the principal causes which conduced to the prevalence of these maladies. Koch's discovery gave emphasis to a suspicion, which had been entertained somewhat feebly long before, that these maladies may be contagious, but it did little more. The profession had long been aware that deficient food, overcrowding, a damp subsoil, exposure to dust in workshops, and a number of other agencies were very influential in this direction. Statistics had shown that the dwellers in towns suffered much more than those who lived in the country, and that out-of-door occupations, if assisted by good food and clothing, afforded the conditions most likely to prevent consumption. Earnest recommendations based upon this knowledge had been repeated over and over again, and the education of the public was fairly well advanced. Owners of house property had in many instances recognised their responsi-

bility, and from those who had not done so the law had in many instances compelled attention. There can be no question that during the last half-century the dwelling-houses of all classes, and more especially of the poorer class, have been very greatly improved. During the period with which we have to deal there has been a very remarkable growth of large towns. It is probably a mistake to suppose that this has been attended to any appreciable extent by depopulation of the country districts, but there can be no doubt that, as compared with fifty years ago, a much greater proportion of the population now resides in towns. Since, as we have just noted, country life is acknowledged to be much more protective than town life, the fact that, in spite of this change in residence, tuberculosis has gone on decreasing, supports the belief that the newly-built suburbs which have sprung up around all our large towns have been constructed under good sanitary conditions. We must give the jerry-builder his due. Side by side with this development of town life it is to be noted that the means of transit from place to place and for the obtaining of change of air have very greatly increased.

Foremost probably amongst the influences which have been at work should be mentioned the improved supply of good food. The repeal of the corn laws stands first among the agencies in this direction, but with it go the maintenance of peace and national prosperity, and the immense development of our commerce. Not only has the best wheaten bread become cheaply accessible to all, but there has been a vast increase in the consumption of various articles of animal food. Mr. Long tells us, we know not with what degree of approach to accuracy, that the consumption of fresh meat is now four times what it was, and if this be true it is perhaps in itself sufficient to account for almost the whole of the results. But with it also we have had the utilisation of the fish-oils and the increased consumption of butter, sugar, etc., which have all taken their share. It may easily be the fact that the popular knowledge of the efficacy of cod liver oil is now the means of preventing annually the development of many thousand cases of phthisis.

As regards the use of the alcoholic hydrocarbons the question has a double aspect. No one doubts that intemperance, especially in the use of spirits, is very prejudicial to the tuberculous. But on the other hand it may be the fact that the moderate employment of

wine and beer is the reverse. Now, if the facts on this head could be fairly set forth we should probably find that although the consumption of alcoholic beverages has not diminished during the last half century, yet that intemperance in their use has been very greatly restrained. The gross total consumed is not less, but it is distributed over a much larger number of individuals, and may thus be supposed to be productive of much less harm.

It must not be omitted to mention that legal enactments as regards the ventilation of workshops, and the prevention of over-crowding and of excessive hours of labour, have no doubt exercised an important influence.

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#### SPRENGEL'S SHOULDER.

WE may direct the attention of those who are interested in the discussion as to this peculiar condition to two important papers in the *Transactions of the Medico-Chirurgical Society*. They occur in volumes lxiii. and lxvi., and are by Mr. Willett and Mr. Walsham, writing conjointly. In these papers two very similar cases are described, which in some features resembled those to which Sprengel's name is for the time attached. In them the scapula was elevated, and to some slight extent the movements at the shoulder-joint were restricted. In both the condition was probably congenital. Thus far they coincide with the cases in which we have recently been interested. There is, however, the very important difference that in these cases an adventitious plate of bone extended from the upper angle of the scapula to the spinous processes of the vertebræ and fixed the bone. No such fixation has been present in any of the Sprengel cases, but it is worthy of note that in most of these there has appeared to be an overgrowth of the upper angle of the bone. It has been supposed to have been proved that this overgrowth is not real, but its semblance has been such as to lead to an excision in more than one case. In one of the Willett-Walsham cases the adventitious plate of bone was excised, and its exact relations, size, &c., demonstrated. The conjecture is ventured by these authors that it represents the supra-scapula which exists in certain fish and

batrachians. We have given reasons for suspecting that the conditions present in "Sprengel's shoulder" imply some arrest in the development of the shoulder-girdle, and that the suggested weakness of the lower half the trapezius is of congenital origin, and one part of the group. Thus it may be that the "Willett-Walsham shoulder" affords another and yet more emphatic example of this occurrence. Much, however, remains to be examined and observed respecting the whole group, and it is quite possible that it may be found that we are dealing with two, or perhaps three, quite different conditions. Dr. Hughlings Jackson believes that in one at least of the paralytic cases which he has seen, great benefit was obtained from galvanism, and he doubts whether the elevation of the scapula, which is the prominent feature in all, is always congenital. There is at present a very interesting example of the Willett-Walsham type in the Hospital for Sick Children, Great Ormond Street.

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#### COLLEGE NOTES.

DR. EWART has been elected Chairman of the Finance Committee in place of Mr. Malcolm Morris, resigned.

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MR. E. T. JOHNSON has been appointed Corresponding Associate for Mombasa.

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ARRANGEMENTS are in progress for a Clinical Visit to the Margate Sea-bathing Infirmary. Those desiring to join are requested to send their names to our Medical Superintendent.

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OUR various classes for the current term have filled well. In the Pathological Department (Captain Pinch) it has been necessary to constitute an overflow class.

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THE attendance at the Clinical Demonstrations and Lectures has been during the past month unusually good.

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A DISPLAY-CASE of Surgical Instruments has been fitted up (in the lobby of the Museum) by Mr. Montague, of New Bond Street.

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THE Standing Committee on Yaws will meet on Thursday, November 14th, at 5.30, when Sir William Kinsey will read a paper. That on Climate and Medical Geography will meet on Thursday, the 21st, at 5.30, when several communications will be read.

## SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

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ON THE PRINCIPLES OF LOCAL TREATMENT IN  
DISEASES OF THE UPPER AIR PASSAGES.

[*Abstract.*]

BY SIR FELIX SEMON, M.D., F.R.C.P.

### *Lecture I.*

IN his introductory remarks Sir Felix Semon described one or two examples of the practical therapeutic advances which have been made during recent years in the surgical or topical treatment of affections of the nose and throat. Amongst these he mentioned the removal of adenoids in suitable cases, and the recognition and operation on empyemata of the accessory nasal sinuses. Success in these and other similar conditions had, however, he considered, led to exaggeration of the benefits, capabilities, and area of application of surgical measures. Hence there had developed, both in the public and in some sections of the profession, a positive "lust of operation," which was producing grave abuses, and would inevitably, sooner or later, be followed by a reaction, to the prejudice of wise and wholesome surgery. Under the influence of this operative exaggeration, operations are being performed where they are not needed; surgical proposals are being made and carried out on the basis of unproven theories; and operative interference is often unduly severe and protracted. It therefore seems necessary to attempt to define the principles upon which the local treatment of affections of the upper air passages should be based, even though it cannot be expected that such a definition can be made either absolute or final. For this purpose the affections now in question may be divided into various groups.

(I.) In the first group may be placed *affections of a purely local character*. Here the question whether local treatment should be adopted or not is of comparatively easy determination. If the disease is causing considerable local discomfort or serious disturbance of the general health, and is amenable to local measures, these should be at once adopted. Delay is not only useless but prejudicial. The proposition just stated embraces all the various forms of obstruction of the upper air passages, provided only that the condition is producing decided local discomfort or appreciable injury to the general health. In many of these conditions prompt local interference is not only advisable, but is absolutely necessary. As illustrations of this position may be mentioned foreign bodies, and malignant disease of the larynx. A foreign body, whether in the nose, pharynx, or larynx should never be allowed to remain, even though at first it may cause no serious symptoms. The clinical history of malignant disease of the larynx is full of encouragement when the disease is early recognised and completely removed. On the other hand, the examples are only too numerous of the danger of delay, which means, at best, a more formidable operation with greater probability of recurrence, and only too often allows a degree of development of the disease beyond the resources of the surgeon's art. It should be adopted as an imperative rule, that obstinate hoarseness in a middle-aged person demands peremptorily a laryngoscopic examination, and the public should be educated to know that early removal of malignant disease offers good prospects of a lasting cure.

The success of local treatment in the above and similar conditions is, however, no defence for operative interference with slight deviations from the normal unattended by direct symptomatic consequences. The discovery, often accidental, of a small crest or spur on the nasal septum, of a limited puffiness over the turbinate bones, of a small bunch of adenoid tissue in the vault of the pharynx, of a somewhat prominent tonsil, or of a uvula looking elongated to a critical eye, is not necessarily a claim for local or surgical treatment. That in conditions of this kind a great deal of unnecessary local tinkering is indulged in, is undeniable, but the practice is to be earnestly deprecated in the interest both of the patient and of the good name of the profession.

In the latter part of his lecture Sir Felix Semon discussed the question of adenoids in relation to their treatment by operation. From this point of view he divided the cases into three groups, viz.:—(a) Those causing permanent symptoms; (b) those in which the symptoms are periodical and transitory; and (c) those which are unaccompanied by symptoms.

In the first group—a very considerable one—are the cases in which the results of adenoids find expression in such effects as mouth-breathing, snoring, and deafness, perhaps with deformities of the face and chest, and a general depreciation of the health. For these, operation is absolutely indicated, and its results are always very gratifying.

In the second group, periods of nasal obstruction alternate with free intervals, and the question of operation is more difficult. No formula will fit all cases, and in individual instances there may be room for a legitimate difference of opinion. Should the child be seen when the symptoms are active, but with a history showing that these occur at rare intervals and last but a short time—the child being otherwise in perfect health—it may be well to postpone decision until the attack subsides and the patient is seen again during quiescence. On the other hand, if the symptoms are more severe and include such conditions as marked deafness, perforation of the tympanic membrane, otorrhœa, and enlargement of lymphatic glands in the neck, especially if there is with these a tubercular family history, operation is the prudent measure. Between these two extremes are cases concerning which doubt may be reasonably entertained, and individual judgments will vary. When a confident decision is impossible it may be well to place the position and prospects impartially before the parents, and allow them to decide the issue for themselves.

Concerning the third class, it is not infrequent to find even a considerable amount of lymphoid tissue in the vault of the pharynx entirely unaccompanied by resulting symptoms, and these innocent hypertrophies present no reason whatever for operation.

A group of symptoms frequently attributed to adenoids are the so-called "reflex neuroses." Of the existence of these Sir Felix Semon expressed himself profoundly sceptical. If in cases of asthma, enuresis, epilepsy, &c., adenoids are present, and are causing

*direct* symptoms, they should be removed, but no expectation should be indulged in that their removal will lead to the relief of the nervous disturbances of which the patient is the subject.

In reference to diagnosis, digital examination was insisted on as affording the most conclusive evidence.

The operation should be performed under chloroform, the patient being in the recumbent position with the head bent well over the end of the table, and the anaesthetic administered so as not to abolish the cough-reflex. Thoroughness, not speed, should be the ambition of the operator. Recurrence, though a possibility, means in the majority of cases imperfect removal of the lymphoid tissue.

The after-treatment needs nothing more than rest in bed for twenty-four hours, and confinement to the house for a further period of two or three days, an aperient being given on the first evening if there is any rise of temperature. The injection of any "antiseptic" fluid through the nose is inadvisable; such a proceeding is attended by the risk of acute complications in the middle ear.

The treatment of adenoids by "breathing exercises" is entirely without value. After the lymphoid obstruction has been removed, it is necessary to train the patient to respire through the nose, but in themselves such exercises are utterly incapable of diminishing or removing adenoid growths.

Summing up the whole question of the treatment of purely local affections of the upper air passages, it may be allowed that mischief results, and perhaps not occasionally, from doing too little, but at the present moment the tendency to error is in the diametrically opposite direction.

### *Lecture II.*

(II.) The second group of cases discussed were those in which *abnormal conditions of the upper air passages are local manifestations of general or systemic diseases*. The most important of these are associated with (a) tuberculosis, (b) syphilis, (c) central nervous disease.

(a) The local treatment of laryngeal tuberculosis cannot be defined as a routine practice, and each case must be considered on its individual merits. When the condition is one merely of infiltration without breach of surface, local measures for removal of the

diseased tissue are not to be advised, unless the swelling is so considerable as to cause either dysphagia or laryngeal stenosis, the latter occasionally demanding tracheotomy. When ulceration has occurred, the advisability and prospects of topical treatment vary within wide limits according to the situation and extent of the disease. In cases in which the ulceration is limited to one or a few small circumscribed areas on the vocal cords, ventricular bands, or inter-arytenoid fold, the energetic application of lactic acid, combined if necessary with scraping or removal of the tuberculous deposit by the curette, is often attended with gratifying results, provided such treatment is efficiently carried out. The prospects are less encouraging when the epiglottis, the mucous membrane over the arytenoids, or the aryteno-epiglottic folds are the sites of ulceration, though even here local measures similar to those just described are legitimate, and occasionally, when dysphagia puts life in jeopardy, more heroic proceedings—even thyrotomy with scraping and lactic acid application—may have to be undertaken in spite of the risks they entail. But with extensive ulceration, accompanied by perichondritis and caries, or exfoliation of the laryngeal cartilages, *curative* local measures are of no avail. All that can be attempted is to relieve pain and dysphagia, and to accomplish this nothing is so good as the insufflation of orthoform. In all cases of laryngeal tuberculosis the general state of the patient and the condition of the lungs must be weighed in considering the advisability of local treatment. Even moderately advanced lung disease, if other circumstances are favourable, does not forbid it, but in the final stage of phthisis it is useless to attempt anything beyond palliation of the laryngeal symptoms when these are causing the patient distress.

(b) Syphilitic manifestations in the upper air passages do not as a routine practice need anything beyond constitutional treatment. Caries of the bones of the nose, pharyngeal adhesions following ulceration, stenosis or advanced perichondritis of the larynx, often, it is true, demand local measures of the most energetic kind. But the daily use of silver nitrate or copper sulphate to syphilitic ulcers has no advantage, and ought not to be practised.

(c) There are two laryngeal affections associated with central nervous disease in which the question of local treatment arises, viz., functional aphonia, and bilateral abductor paralysis of the vocal

cords in tabes. The first is best treated by prompt and decided intra-laryngeal faradisation ; the preliminary use of electricity externally is to be deprecated, as it appears to qualify the success—usually the very ready success—of the intra-laryngeal method. The bilateral paralysis of the abductors which sometimes attends tabes dorsalis suggests a prophylactic tracheotomy with a view to avoid the danger of sudden suffocation which necessarily attends on these patients. On the other hand, experience shows that many of these cases get on very comfortably even with a very narrow glottis, and that in some instances the extension of the paralysis to adductor muscles widens after a time the glottic space. Hence the question of interference is a difficult one, and perhaps after the patient has been informed of the risks and chances the decision should be left to his own choice.

(III.) In a third group may be placed *local manifestations in the nose and throat the result of disease affecting areas anatomically or otherwise connected with the upper air passages.* Laryngeal paralyses consequent on thoracic aneurism, mediastinal tumour, or cancer of the oesophagus, are examples of this class. The local treatment can only be symptomatic, the chief therapeutic claim being the removal, if possible, of the causal conditions. The same sound principle holds good when inflammatory conditions of the pharynx or larynx are associated with more or less complete nasal obstruction, for it is manifest that such conditions must tend to be obstinate to topical treatment when nasal respiration and its functions of moistening, warming, and purifying the inspired air, are seriously diminished or altogether abolished. But this does not justify the ridiculous doctrine that *all* inflammatory processes in the pharynx or larynx are secondary to some pathological intra-nasal condition. That doctrine has in some quarters entered into practice to such an extent as to lead to numerous unwarranted operations, slight deviations from what is pictured as a normal nasal cavity being removed or otherwise attacked on the assumption that they are responsible for the infra-nasal disturbances.

(IV.) There remain for consideration *local conditions of the upper air passages supposed to exercise an influence upon other parts of the body.* In some that influence is direct, in others it is alleged to be reflex. Whilst there is a measure of truth in both these pro-

positions, each has been highly exaggerated and has formed the basis for much injudicious and meddlesome practice. It is, for example, beyond question that catarrhal processes originating in the naso-pharynx may spread through the Eustachian tube to the middle ear ; that adenoid hypertrophy may lead to deafness, and to malformation of the face and chest ; and that the absorption of purulent nasal discharges may cause general septic poisoning. For the secondary consequences of the local conditions in each of these instances there are abundant explanations based upon both reason and experience. But to advise that a spur of the nasal septum should be removed because its presence threatens the efficiency of the auditory apparatus, is contrary alike to facts and to common sense. As regards the alleged reflex-influence of nasal conditions Sir Felix Semon expressed himself as entirely sceptical of the capacity of such conditions to produce the catalogue of evils which some authorities attribute to them. That judicious treatment of a pathological condition of the nasal mucous membrane is often successful in the treatment of hay-fever, and that removal of nasal polypi may cure a case of asthma, is beyond question, but in the great majority of cases it is impossible to say beforehand whether an existent neurosis does or does not depend upon reflex excitement having a nasal origin. Even in bronchial asthma associated with swelling of the anterior parts of the lower turbinals, treatment of the local condition more often fails than it succeeds, and there is nothing to guide the practitioner in the selection of the probably successful cases. The case is still stronger against conditions which have no common-sense relationship to the symptoms for which they are sometimes held responsible. "Varicose veins" at the base of the tongue, which were at one time accused of many forms of local and reflex crime, have found a more recent successor in the form of the "nasal spur." It is to be hoped that this in its turn will follow its predecessor into an unhonoured grave. The attempt to find the explanation of all kinds of symptoms and sensations in some tiny abnormality in some part of the upper air passages is little calculated to do good to the patient, or to reflect credit on the medical attendant.

In conclusion, Sir Felix protested against the severe operative measures practised in some local disorders of the nose and throat

He instanced the case of leptothrix-mycosis or keratosis of the tonsils in which no local treatment whatever is required, the condition entirely disappearing under change of air, rest, and tonics; the removal of the whole of the lower turbinal by the "spokeshave"; and the proposal to extirpate the entire larynx, together with the neighbouring areas of possible lymphatic infection, in laryngeal cancer, even when an early diagnosis is made and the disease is of strictly limited extent.

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### MULES' OPERATION AS A SUBSTITUTE FOR EXCISION OF THE EYEBALL.

[*Abstract.*]

BY R. BRUDENELL CARTER, F.R.C.S.

THE operation introduced by Dr. Mules in 1881 consists in the evacuation of the contents of the sclera and in the insertion into the cavity, of a glass globe, over which the sclera is united by sutures. In this way is formed a globular stump, in front of which is worn a coloured scale or artificial eye. The advantages of this procedure, as compared with the removal of the entire eyeball, are considerable. In the first place, as the sclerotic is retained together with its muscular attachments, the patient is able to impart to his artificial eye a fair measure of movement, and thus avoids the fixed stare which attends the ordinary glass eye. Secondly, the globular stump fully occupies the space previously filled by the eyeball, and the upper lid is thus kept in its natural position, as compared with the hollow left between the lid and supraorbital ridge after removal of the eyeball. Similarly, the bulk of the stump ensures, when the operation is performed in early life, the natural development of the cavity of the orbit and of the neighbouring bones, and in this way secures the symmetry of the face. The cosmetic effect of the operation in these and other respects is therefore much superior to the results which follow removal of the eyeball, and, apart from mere appearances, this consideration has often a practical value, more

especially in the case of women engaged in business occupations where an unpleasant deformity would be to their disadvantage.

In the performance of the operation ordinary aseptic precautions are adopted, the lids are kept open by means of a speculum, and a fixation hook is inserted into the centre of the cornea. Then the circle of the cornea is cut out, the lens and vitreous are allowed to escape, and the choroid and ciliary nerves are thoroughly scraped off, so as to leave the inner surface of the sclerotic perfectly clean. This latter procedure is usually attended by rather free bleeding, which is best checked by the insertion of a small rubber ball connected with a tube and stopcock, and distended, after its introduction, by means of an air syringe. After the bleeding has in this way been checked by pressure, the circular opening left by removal of the cornea is made elliptical by incising the sclera in the horizontal meridian both to the right and left, and by cutting off the resulting corners. The next step is the introduction of the glass globe. This is effected by a special instrument, which keeps open the wound and allows the globe to be pressed into the cavity without turning in the cut edge of the sclerotic. It is of great importance that the globe shall accurately fill the scleral cavity, and it is well to have two or three of various sizes at hand. The adjustment ought to be such that the margins of the incision may be united by sutures without strain. The sutures which should be inserted into the sclera about a quarter of an inch from the incised margin, are then brought across the front of the glass globe; they are removed seven or eight days after the operation.

The operation is usually followed by free swelling of the lids and conjunctiva, but this is seldom attended by much pain, and soon subsides.

With an experience of about one hundred cases, Mr. Carter is fully convinced of the great value of this method, which has not, he considers, received in this country the acceptance it merits.

The operation may fall short of complete success in consequence of failure to obtain perfect union of the scleral wound. In these circumstances a small gap is left in the sclerotic through which the glass globe may be seen and touched. When this is the case, the pull of the muscles upon the sclerotic invariably makes the gap gradually increase, and by the time this has enlarged to a diameter

of 4 to 5 mm., the patient suffers more or less pain, and it is best to open up the wound and allow the glass globe to escape. Even when this happens the condition is better than that left by removal of the eyeball; for the stump formed by the collapsed sclera is decidedly superior to that produced by division of the muscles and optic nerve in the ordinary operation of removing the eye. The necessity for taking out the glass globe as a consequence of incomplete union of the scleral wound Mr. Carter has seen in some few cases; in one or two instances this has arisen as long as four or five years after the original operation.

Concerning the possible development of sympathetic ophthalmia in the sound eye, Mr. Carter stated he had never seen the smallest ground for anxiety. In one patient there was some pain and conjunctival swelling about two years after the operation, but these symptoms subsided after the application of a leech and the use of a simple lotion. A year or so later they recurred, and the "eye" was removed on grounds considered adequate by the surgeon then in attendance. The same thing was done in another case ten years after operation, and it was said that pus was present in the scleral cavity. Personally, Mr. Carter has never seen any such condition. It is certainly of great importance in the operation to thoroughly clear all vascular and nervous tissues from the inner surface of the sclerotic, but provided this is done, the possibility of sympathetic ophthalmia can scarcely be allowed, and experience shows, as a matter of fact, that it does not occur.

The lecture was illustrated by several patients in whom the natural appearance of the artificial eye and its considerable range of movement were well illustrated. In one of them the ball had been thirteen years in position; and in another, a boy of 14, ten years. Mr. Carter had performed the operation on patients ranging from 9 months to 70 years of age.

## ON PERINEAL BLADDER DRAINAGE WITH CONTROL.

[*Abstract.*]

BY REGINALD HARRISON, F.R.C.S.

MR. REGINALD HARRISON lectured on this subject, and by means of fifteen illustrations, copies of which were handed round to each member present, he described the steps of the operation and the temporary and permanent apparatus used in connection with it. He proposes in this way from time to time to illustrate many of the operations on the urinary organs, and to refer to details which were not usually described in text-books. From their nature and circumstances of application, these operations are not very advantageously presented and learned on the dead subject. By means of illustrations placed in the hands of his audience Mr. Harrison hoped to be able to render his explanations sufficiently clear for practical purposes to everybody. Many of the illustrations would be from original drawings made by himself.

Perineal bladder drainage with control, as he should describe it in contradistinction to drainage alone, was a safe and efficient method of treatment which was applicable to many serious conditions of the urinary organs arising from obstructive disorders such as prostatic enlargement and stricture in chronic suppurative conditions of the bladder and upper urinary passages, in pouching and sacculation of the bladder, and for conditions of irreparable stricture of the urethra. He should describe the operation as used for (1) temporary or (2) permanent purposes.

In some respects it resembled Cock's operation for impassable strictures, with this difference, that the introduction of a staff into the bladder, however small it might be, was necessary for the operation he proposed describing, which was known under the name of perineal section or external urethrotomy. Cock's operation had largely fallen into disuse, for the reason that, mainly arising out of the great improvement that had recently taken place in the construction of all kinds of urethral instruments, impassable strictures were not so often met with. He had always taught and advocated

the doctrine of Syme that a urethra which was at all viable to urine in however small quantity could not be regarded as impassably strictured. He had seen no reason to modify this view, and it was a sound principle for teaching and practical purposes. The precise form of operation, from the preliminary incision to the introduction and fixing of the drainage tube, was then described by Mr. Harrison, the auditors following the successive stages on the illustrations placed in their hands. The different kinds of drainage tubes for temporary and permanent purposes, and their mode of application, were then shown and illustrated, and the subsequent management of them discussed. A patient, aged 32, who had recently undergone this operation (five weeks previously) was shown, and the features of his case pointed out. His urethra was involved in a dense mass of cicatricial tissue caused by a fracture of the pelvis with a rupture of this canal a year ago in South Africa. The particulars of other cases where temporary or permanent drainage had been employed were read :—

CASE I.—Male, aged 67, advanced prostatic obstruction with cardiac failure and oedematous legs. Tubing and control drainage in 1889. Permanent use of apparatus without further catheterism. Restoration to health and active life. Patient lived for seven years afterwards.

CASE II.—Male, aged 39, recurrent cystitis for ten years, associated with much spasm and bladder pain incapacitating him for work of any kind. Tubing and control drainage October, 1899. Still wears apparatus, October, 1901, and is in perfect health, leading an active life.

CASE III.—The patient, aged 32, shown at the demonstration. Traumatic stricture following fractured pelvis and ruptured urethra. Tubing and temporary drainage on August 28, 1901. So far with good result, but if the stricture recontracts, as it possibly will do, permanent control drainage will be substituted.

CASE IV.—Male, aged 38, commercial traveller. Extremely contractile stricture treated previously by suprapubic aspiration and various forms of dilatation. Tubing and control drainage October, 1900. Wears the permanent apparatus up to present date (October, 1901). Leads an active life as a traveller in complete comfort.

CASE V.—Male, aged 63, prostatic obstruction, foul urine, and constant painful catheterism. Tubing and control drainage, April, 1901. Still continues to wear apparatus up to present date (October, 1901) with comfort and restoration of urine to natural condition. Able to go for change to Brighton and to take a walk twice a day. Continues to improve. No necessity for catheter. (The apparatus is worn both by day and night so that uninterrupted sleep can be obtained for some hours, varying relatively to bladder capacity.)

Mr. Harrison concluded by announcing that at his next demonstration, on December 4, he would take for his subject, and illustrate in a similar way, internal urethrotomy and the manner in which he combined, for various purposes, the operations of internal and external urethrotomy.

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## ON CONGENITAL TALIPES EQUINO-VARUS.

[*Abstract.*]

BY A. H. TUBBY, M.S., F.R.C.S.

CASES of talipes equino-varus may, as regards their etiology, be placed in three groups, viz.: (1) Those of congenital origin; (2) those resulting from infantile paralysis; and (3) those due to spastic paralysis in infancy.

Congenital cases are by far the most common. Most authorities are now agreed that these cases result from close packing of the foetus *in utero*, the feet in this way being turned inwards towards one another. Congenital cases are distinguished from those due to paralysis by the following facts: (1) In congenital cases both limbs are usually affected; (2) the condition of the limb is otherwise normal, whereas in paralytic cases the affected limb is stunted, shrunken, blue and cold, and there is more or less muscular atrophy; (3) an attempt to place the foot in the normal position encounters a sense of elastic resistance, whilst in paralytic club-foot there is no resistance to passive movement unless muscular shortening has occurred.

Congenital equino-varus is not a simple, but a compound deformity. It involves changes at the medio-tarsal joint which are

responsible for the inward inclination of the foot, and changes at the ankle-joint, on which the drawing-up of the heel depends. Probably the earliest structures affected *in utero* are the yielding bony and cartilaginous tissues of the foot, but in every case of at all a severe degree, it is found shortly after birth that, in addition to an increased inward inclination of the neck and head of the astragalus, and defective development of the tuberosity and inner part of the scaphoid, there is also shortening of the anterior part of the internal lateral ligament, of the tendons of the tibialis anticus and posticus, and of the inner band of the plantar fascia.

The treatment must vary according to the severity of the case. When the foot can be completely replaced in the normal position, a cure may be effected by persevering manipulation devoted to bending the foot outwards, and dorsi-flexion at the ankle-joint. In most cases, however, there are resistant structures which oppose the replacement of the foot, and these must be divided. In reference to this division three rules may be stated. First, in every case in which the operation is necessary it should be performed at the earliest possible date; there is no advantage, indeed quite the contrary, in waiting until the child is some months old. Secondly, whatever operative measures are necessary these should be conducted in two stages. In the first stage, the division of tendons and ligaments necessary to overcome the inward inclination of the foot should be performed, leaving the heel (in its abnormal position) as a fixed point to obtain leverage in directing the foot outwards, this being accomplished by the use of a suitable splint. Later, when a correct inclination of the foot has been secured, the tendo Achillis is divided, and the foot fixed at a right angle to the leg by a Scarpa's shoe. Thirdly, after a good position has been obtained, it is necessary to keep the patient under observation during the whole period of growth, in order to meet the tendency to relapse. Unless persevering and prolonged after-treatment is practised the foot reverts to its vicious position, and when this occurs it is difficult by any measure to gain a satisfactory result.

In some exceptional cases Phelps' operation is of value and may be required; wrenching also is a method of treatment suitable in very resistant cases. Mr. Tubby discouraged operations which involve the bony framework of the foot, at least in

children under six years of age, and he disapproved of the practice of removing the astragalus.

The lecture was illustrated by a number of cases showing various degrees of equino-varus, and by others demonstrating (1) the results of operation, and (2) the unfortunate conditions which are entailed by recurrence due to defective after-treatment.

Two patients with deformities due to infantile paralysis were also presented. In one there was equino-varus from paralysis of the extensors of the foot, with secondary shortening of the muscles of the calf. It was proposed to operate so as to get rid of the articular surfaces of the ankle-joint, and to secure firm fibrous ankylosis between the astragalus and the bones of the leg. In the second case a girl had lost the power of extending the leg from paralysis of the quadriceps extensor. To meet this Mr. Tubby intended to separate the sartorius from its tibial attachment, and to graft its lower end on to the upper border of the patella, thus converting it into an extensor muscle. In all such operations he pointed out some time must be given to allow the muscle to accommodate itself to the lessened distance between its points of attachment. It is only after this has been accomplished that effective contractile action of the muscle in its new position will be displayed.

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## SOME POINTS IN THE ANATOMY OF THE LIVER.

BY JAMES CANTLIE, F.R.C.S.

(*Abstract.*)

THE liver, in terms of descriptive anatomy, consists of a large right and a small left lobe. The line of division between the two is indicated on the upper surface by the attachment of the suspensory ligament, and on the lower surface by the longitudinal fissure containing the round ligament and obliterated ductus venosus. Further, the anatomist, when concerned with existing facts, recognises a subdivision of the under surface of the right lobe. Running to the right, at right angles to the longitudinal fissure, he finds the

transverse fissure, which is met at its right extremity by a line parallel to the longitudinal fissure. In the anterior part of this line, lies the gall-bladder, whilst through its posterior part passes the inferior vena cava. The part of the inferior surface in front of the transverse fissure is the quadrate lobe, and that behind it is the spigelian lobe. In the anatomical description both of these lobes are thus subdivisions of the right lobe. The dividing mark between the right and left lobes is the longitudinal fissure; and the gall-bladder lies, not at the junction of these two lobes, but purely attached to the right lobe at a point some distance to the right of the line where the two lobes unite. Custom and tradition have made this map of the liver generally accepted without question or demur. Otherwise it might well have appeared curious to find the gall-bladder placed, not at the line of union of right and left lobes, but associated in its anatomical relations purely with the right lobe. When the spirit of enquiry has once been aroused other facts, apparently strange, are detected. Thus, when the hepatic artery is traced into the transverse fissure it divides, as every student knows, into a right and left branch, these two being of equal size. In spite of the fact that the left lobe is not more than one-third the bulk of the right it appears to receive a nutrient artery equal in size to that passing to its larger neighbour. Exactly the same is true of the portal vein and its division into a right and left branch. These are statements which demand some consideration. They certainly justify a reconsideration of the traditional description of the hepatic plan. If they convey the truth, the whole truth, and nothing but the truth, the arrangements of the blood supply to the two lobes of the liver are certainly unique among the physiological mechanisms of the human body. There are, however, a number of facts to show that the inferences which inevitably attend the usual anatomical sketch of the liver are incorrect. The details of the plan are accurate, but the interpretation of their significance is erroneous. It is true that the hepatic artery divides into right and left divisions, and that these two divisions are of equal size. But it is not true that the distribution of these two branches is to the so-called right and left lobes respectively. On the contrary, it can be shown that the area supplied by the right hepatic artery is that part of the liver mass which lies to the right of the gall-bladder, whilst the left

hepatic artery embraces the entire district to the left of the gall-bladder, that is, not only the left lobe but also the quadrate and spigelian lobes. And what is true of the two divisions of the hepatic artery is true, in equal measure, of the two divisions of the portal vein. In other words, so far as the vascular arrangements of the liver are concerned, the line of division runs, not in the furrow of the longitudinal fissure, but considerably to the right of this, namely, at the so-called fissure of the gall-bladder.

Again, if the liver be divided from before backwards so that the line of section passes from the attachment of the gall-bladder to the inferior vena cava, it is found that the organ is divided into a right and left half of approximately equal bulk. Thus the amount of hepatic tissue supplied by the left hepatic artery and left portal vein is practically equal to the amount supplied by the right hepatic artery and right portal vein ; and a justification of the equal division of each of the two main trunks is in this way supplied.

The facts of the vascular distribution being as just described, and the further fact that there are practically no anastomoses between the two areas in the hepatic substance, explain the occasional occurrence of rupture of the liver with an inconsiderable amount of haemorrhage. Provided only the line of injury follows what may be called the antero-posterior line of the gall-bladder, there is, as it were, merely a splitting of the liver between two distinct arterial districts, and thus no free bleeding occurs. Similarly, it follows that when circumstances demand operative interference with the deeper part of the liver it is along the same line that the surgical pathway of safety lies. Again, a knowledge of the vascular plan of the liver explains the limited distribution in some instances of malignant or other tumours to the right and left of the gall-bladder, and holds out a not unreasonable hope that by ligaturing the corresponding branch of the hepatic artery the further growth of such tumours may be checked by a control of their blood-supply. All these are practical points arising out of a knowledge of anatomical facts capable of actual demonstration. But the same facts suggest a revision in the usual description of the liver. It is quite true, as custom prescribes, that the organ on its inferior surface is divided into a small left and a large right lobe. But these anatomical terms do not correspond to the areas of vascular supply. The study of these areas shows that

the true line of division is the line of the gall-bladder. Such a line divides the organ into masses of equal bulk, and explains the position of the gall-bladder at the junction of the two. There are, in short, two livers, a right and left, equal in bulk, having an equal blood supply, and each provided with a duct that opens into a common receptacle, the gall-bladder, which lies at the point where the two organs are united into a single anatomical mass. When one liver becomes incapacitated, as it may do from a hydatid destroying its tissue and leaving after evacuation a cicatrical mass, the other becomes hypertrophied, and the hepatic functions are pursued without prejudice to the economy. The parallel with other paired organs of the body is exact, both from an anatomical and physiological standpoint, if only the arbitrary line of the longitudinal fissure is abandoned and the true right and left lobes are recognised as lying respectively to the right and left of the line of the gall-bladder.

Embryology points no less certainly to the same conclusion. The liver is first seen as a double process or bud from the primitive alimentary canal. In current phrase, after a certain date the left bud ceases to grow, and thus there ensues a lop-sided organ with a small left and a large right lobe. But with the recognition of the facts as above stated, it is seen that the adult liver, no less than the primitive organ, is a symmetrical structure consisting of two equal masses, fused, it is true, into one organ, but having most appropriately and reasonably at the line of junction the sac of the gall-bladder to receive impartially the secretion which both the right and the left liver provide doubtless in equal measure. There is without doubt a right and a left lobe of the adult anatomical liver. But these are of equal, not unequal, bulk; they receive an equally-abundant blood supply; and they claim a common share in the gall-bladder which marks the dividing line between them.

## NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

### MEDICAL CASES.

BY C. THEODORE WILLIAMS, M.D., F.R.C.P.

*Tuesday, October 8, 1901.*

#### *Cases of Phthisis Pulmonalis.*

THE case of a young woman afforded striking evidence (1) of the chronic course pursued by some cases of pulmonary phthisis, (2) of the method of arrest by fibrosis, and (3) of the displacement of the heart which may be produced by shrinking of the fibrous tissue. The patient had been under observation at intervals during many years, and at present was enjoying a fair measure of general health. At one time there had been extensive cavernous signs in the upper part of the left lung, but these were now limited to a small area in the first intercostal space and to the upper interscapular region. The cavity had evidently undergone contraction owing to the formation of fibrous tissue, and, as is usual, this contraction had taken place towards the root of the lung. The cardiac displacement was exceptional both in direction and degree. It is not infrequent when fibroid phthisis affects the left lung to find the cardiac impulse drawn up towards or even into the left axilla. But in the present case the impulse was felt immediately below the inferior angle of the left scapula, and it was at this point that the cardiac sounds were most distinctly heard.

In a second case, the frequent association of pleural effusion with tubercle was illustrated. The patient, some twelve months ago, had undergone paracentesis thoracis, and subsequently tubercle bacilli were detected in his sputa. Dr. Williams emphasised the importance of remembering, in reference more especially to prog-

nosis, that pleurisy and pleuro-pneumonia are frequently manifestations of tubercle. The bacilli may be detected in the fluid withdrawn from the chest though the patient is entirely free from the usual symptoms and physical signs of tubercular pulmonary disease.

*Cases of Bronchiectasis.*

Two cases were shown to illustrate (1) the chronic course of the disease, (2) the slight extent to which the general health suffered, and (3) the large amount and fœtor of the expectoration. One patient had had haemoptysis on two occasions and had suffered from repeated attacks of pneumonia. In one of the cases great improvement had followed the inhalation of creasote vapour.

*Tabes Dorsalis with Rectal Crises.*

The patient was a man of 30 years. The chief feature of interest in the case was afforded by the contrast between the slight development of the ataxia and the severe degree of the visceral disturbances. In the gait of the patient under ordinary circumstances there was little or nothing to criticise, but when trying to walk along a single plank he became distinctly unsteady. The knee-jerks were absent, and the pupils were unequal and showed no response to light. These facts placed the diagnosis beyond doubt. But none of them caused the patient much practical inconvenience. On the other hand, he had for three years completely lost control over his bladder and was entirely dependent on the use of the catheter. During the last twelve months, too, he had suffered at frequent intervals from urgent tenesmus and great pain in the rectum, compelling him to make repeated efforts to empty the bowel. It is noteworthy that this disturbance of the functions of the bladder and rectum was unattended by any considerable decline of sexual power. He is the father of three healthy children, the youngest being six months old. His wife has enjoyed good health and has not at any time had a miscarriage, though patient admits a venereal sore eleven years ago followed by an eruption on the face, and he has been treated for long periods by mercury and potassium iodide. What he particularly desired was relief from the agony of the severe pains about the rectum. In connection with these it is to be remembered that the visceral crises of tabes dorsalis, like the

lightning pains, sometimes spontaneously disappear. It was decided to advise the use of antipyrine when pain was troublesome, and the steady administration of aluminium chloride. The fundus oculi was normal on each side, and there was no contraction of the visual fields.

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BY SIR WM. H. BROADBENT, BART.

*Tuesday, October 15, 1901.*

*Cardiac Murmur varying with posture of Patient.*

THE patient in whom this murmur was observed was a man of 37 years. Never perhaps very robust, and subject to attacks of "relaxed sore throat," he had still been free from any serious illness—in particular, he had never had rheumatic fever, and the family history was entirely free from any suggestion either of rheumatism or heart disease. The symptom for which he sought relief was pain over and to the left of the praecordial region, and this he regarded as the result of a bicycle accident some two years ago. The pain was more or less constant, was not apparently affected by food, but was aggravated on exertion. The patient also admitted the existence of breathlessness and palpitation on exertion, but these had never been at all extreme, and he himself attributed them to "flatulence" from which he had long suffered. At no time had there been haemoptysis. The urine was reported free from albumen and sugar.

In examining the praecordial region, the patient being in the erect posture, Sir Wm. Broadbent noted the following facts:— Cardiac impulse somewhat feeble perhaps, but well defined, and situated in the fifth space about half-an-inch within the nipple line; praecordial dulness of normal extent; over the impulse is a systolic murmur continued from the first sound; the murmur can be readily traced to the left as far as the mid-axillary line, and can even be heard feebly over the base of the left chest. When the patient is made to lie down the auscultatory signs undergo a decided change. The murmur is now scarcely audible, and is no longer directly continuous with the first sound; that sound, indeed, is quite pure, and the murmur is separated from it by a short interval. Repre-

senting the normal sounds by counting 1, 2,—1, 2, the conditions here are as if one counted 1 and 2,—1 and 2, the murmur taking the place of the "and." Exertion on the part of the patient also makes the murmur less distinct. The suggestion had been made that the murmur was of exocardial origin, possibly due to a limited pericarditis resulting from his bicycle accident. This suggestion, however, Sir Wm. Broadbent was unable to accept. Against it he urged the blowing quality of the murmur, and the fact that firm pressure produced no change in it; the area of distribution over the apex and to the left of the apex instead of, as is usual in pericardial friction, over the region of the right ventricle; and the absence of all signs of pericardial adhesion, the site of the impulse changing considerably as the patient was placed alternately on his right and left side. It is rather to be supposed that there exists some condition of the valvular curtains and their chordæ tendineæ which, in some positions of the body, permits more effective closure of the mitral orifice than in others. When the patient was placed on his left side the apex shifted to the left to an extraordinary extent, and a forcible thrust was felt outside the anterior axillary line, showing an unusual mobility of the heart, as if it were not supported by the pericardium.

In reference to the diminished intensity of the murmur observed after the patient had walked smartly two or three times across the room, Sir William remarked that a similar experience is not uncommon in boys liable to suffer from cardiac dilatation after strain. The patient may be seen with the cardiac impulse and left percussion border some distance to the left of the nipple line, and having a distinct systolic murmur in the region of the apex. Exertion, for example hopping on one foot for a limited period, rectifies all this. The impulse and the line of dulness retreat within the nipple line, and the murmur disappears. The exercise acts as a stimulus to the heart, which, by more powerful contractions, is enabled to empty its several chambers; at the same time the muscular ring surrounding the auriculo-ventricular orifice acts more strongly, and thus efficient closure of the orifice is secured. Sustained and more violent effort, for example a football match, on the other hand, has exactly the opposite effect. It exhausts the power of the cardiac muscle, and dilatation of the cavities and imperfect

closure of the auriculo-ventricular valves are therefore increased. These are the cases in which Oertel's treatment by systematised hill-climbing proves to be beneficial.

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R. L. BOWLES, M.D., F.R.C.P.

*Tuesday, October 22, 1901.*

DR. BOWLES demonstrated (1) several cases of phthisis pulmonalis, exhibiting the physical facts which mark the various stages of the disease; (2) a case of mitral stenosis; (3) an example of hemiplegia in a young woman free from cardiac disease and without evidences of hysteria or syphilis; and (4) a girl who displayed weakness of the lower limbs with absence of the knee-jerks.

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HARRY CAMPBELL, M.D., F.R.C.P.

*Tuesday, October 29, 1901.*

*Empyema in Childhood.*

THE patient, a girl of 4 years, was, when she first came under observation, extremely ill. She was much emaciated, and it seemed probable that she would die. It is, however, a frequent experience to find that an untreated empyema in a child produces a very unpromising set of symptoms, and yet on evacuation of the pus the patient at once shows evidences of improvement, and in the end makes a complete recovery. Hence the prognosis is by no means so bad as the general condition of the patient at first suggests. So long as pus remains in the pleural cavity, so long will there be septic absorption and evidences of blood-poisoning. But when the cavity is drained, the source of the mischief is taken away, and the general nutrition of the patient moves at once in the direction of health. There is, therefore, every reason and encouragement to insist on the importance of surgical measures in the treatment of the empyemata of childhood, and these almost inevitably include, in order that drainage may be free, resection of one or more ribs. It is a noteworthy clinical fact, the readiness and frequency with which pus forms in the pleural cavity of children as compared with adults.

Whether arising from an original pleurisy or from a pneumonia, fluid which has been present in the pleural cavity of a child for a week or so, will almost certainly be found to be purulent.

Criticising the proposal to attempt to promote expansion of the lungs by means of special calisthenic exercises directed to enlargement of the chest, Dr. Campbell expressed himself as doubtful of the advantage of this method. Dumb-bell drill, and exercises of a similar order, will no doubt improve the development of the muscles of the chest and upper limbs, but this does not necessarily mean increased respiratory efficiency. Indeed, such exercises by tending to cause fixation of the chest wall may actually lessen the range of lung inflation. The ordinary games of active childhood are, for this end, much to be preferred to any special calisthenics. They produce during their practice more or less dyspnoea, and this condition necessarily means over action of the inspiratory muscles. It is from this direction that improvement in the development of the healthy lungs, and such an amount of expansion of crippled lungs as is wise, are to be expected.

#### *A Case of Extensive Muscular Atrophy.*

The patient was a woman of 24 years, in whom there was seen extensive and widespread muscular atrophy. The complaint had commenced about a year ago with difficulty in raising the head, and this condition had now reached such a degree of severity that the head, unless supported, fell forwards with the chin on the sternum. Similarly, when the head was carried into a position of over-extension, the patient was unable to raise it into the erect position. The sterno-mastoids, the upper portions of the trapezii, and the post-occipital muscles generally, presented a condition of extreme atrophy and weakness. In each upper limb similar but less extreme atrophy and weakness were appreciable in the serratus magnus, the pectoralis major, the biceps, and the small muscles of the hand ; the forearms for the most part had escaped, though there was some weakness of the extensors of the wrists. It was specially noteworthy that the deltoids retained both their bulk and their power. The muscular movements of the trunk were deficient in some respects, and there was distinct paresis of the flexors of the thighs. The knee-jerks were marked and possibly

exaggerated, and the same is true of the triceps-jerk in each upper limb. Sensation was unaffected.

Dr. Campbell discussed the diagnosis as between progressive muscular atrophy and idiopathic muscular atrophy. In the former, of course, the lesion is a degenerative or chronic inflammatory change in the anterior cornua of the spinal cord. The idiopathic muscular atrophies (myopathies) are not dependent on central nervous disease, but are atrophies originating in the muscular tissues themselves.

The one positive fact supporting a diagnosis of progressive muscular atrophy, as opposed to an idiopathic atrophy, is the exaggeration of the tendon-jerks. This may undoubtedly occur in progressive muscular atrophy when the lesion involves, in addition to the anterior cornua, the terminal fibres of the lateral columns. In such a case there is an interruption between the higher cerebral centres and the cells of the anterior cornua (a form of lateral sclerosis), and hence there result such phenomena as muscular rigidity and exaggerated tendon-jerks. These phenomena, too, may be associated with muscular atrophy. For the degeneration of the cells in the anterior cornua occurs in patches. Hence parts of a muscle may be atrophied, whilst other parts, under the influence of the lesion in the lateral column, may exhibit spasticity and increased myotatic irritability. In the present case, then, the state of the tendon-jerks so far harmonises with a diagnosis of progressive muscular atrophy. On the other hand, there are facts which are opposed to this view. First there is the absence of fibrillary twitchings; secondly the commencement of the atrophy in the muscles of the neck; thirdly the distribution of the atrophy, more especially perhaps the escape of the deltoid and the upper part of the triceps muscles, which are almost always involved in progressive muscular atrophy (spinal) when the disease has spread over a wide area. Concerning the family history, all that has to be said is that no other member of the family is similarly affected. This hardly inclines the balance to one side or the other. Idiopathic muscular atrophies are often family affections. But isolated cases occur. The correct way of stating the position is, that when in early life several members of the same family suffer from muscular atrophy, the affection is with great

probability a myopathy, and not the result of central nervous disease. (This case may be usefully compared with two reported in our last issue, pp. 176, 177.)

#### *A Case of Tabes Dorsalis.*

This patient exhibited three features of special interest : (1) He had suffered from severe lightning pains, which had affected the upper, not the lower, limbs, and had now entirely disappeared (see p. 242). (2) The muscular sense was extremely defective; with his eyes closed he was quite unable to guide his limbs to a definite purpose, so that when attempting to approximate the points of his index fingers he would miss his aim often by a foot or more. (3) Sensation was delayed, this being more marked in the case of painful than of ordinary sensations. Pricked with a pin he felt after a few seconds a sense of touch, and then after a further slight delay, a sense of pain.

#### *The Strumous Diathesis.*

The case of a delicate child led Dr. Campbell to discuss the meaning of this phrase. He defined it as a tissue tendency to the development of tubercle due to a low degree of resistance to the action of the tubercle bacillus. Dr. Campbell expressed the opinion that this state of the tissues is for the most part acquired as a result of defective and injudicious food. The latter more especially is responsible for disordered digestion and unhealthy processes in the alimentary canal, and in these conditions the absorption of prejudicial material takes place, and thus the tissues are systematically poisoned and their vitality impaired. The value of mercurials in the alimentary disorders of children is largely due to their power to restrain unhealthy fermentations and in this way to promote tissue health.

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## SURGICAL CASES.

BY P. J. FREYER, M.D., CH.M.

*Wednesday, October 9, 1901.*

Mr. Freyer showed (1) a case of primary ulceration of the bladder in which healing had taken place, (2) two instances of stricture of

the urethra, and (3) a large adenoma of the prostate, removed from a patient 75 years of age, who had for fourteen years suffered complete catheter life, and in whom total extirpation of the prostate had been followed by a successful result.

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## DISEASES OF THE THROAT AND EAR.

BY HERBERT TILLEY, M.D., F.R.C.S.

*Friday, October 4, 1901.*

### *Septic Thrombosis of the Lateral Sinus.*

ONE of the dangers of chronic suppuration in the middle ear was illustrated by a lad who when first seen was very ill, with a temperature of  $104\cdot6^{\circ}$ , and a pulse of 120. He had a ten years' history of discharge from the ear, some recent earache, and possibly a rigor. The local condition showed swelling, redness, and oedema over the mastoid process, where also there was tenderness on deep pressure. There was, in addition, a painful swelling behind the ramus of the jaw extending half way down the neck. These facts showed extension of the disease beyond the limits of the tympanum, and septic thrombosis of the lateral sinus was diagnosed. The clot was removed by operation, and the boy made a good recovery. During convalescence there were on two or three occasions high temperatures ( $100^{\circ}$  to  $101^{\circ}$ ). This, together with the swelling behind the jaw, gave rise to the fear that the septic process was extending to the thrombus in the internal jugular vein, involving a risk of its detachment, with a possibility of pulmonary embolism, septic pneumonia, and general pyæmia. Hence it had been proposed to tie the jugular vein. But in the absence of rigors, and with the generally improved condition of the patient and the diminution of the swelling in the neck, this step was not taken, a decision which had been justified by subsequent events. In connection with the diagnosis the absence of optic neuritis is a noteworthy fact. It is a not infrequent result of sinus thrombosis, and more frequently accompanies that condition than it does the other serious complications of chronic otorrhœa, viz., meningitis and cerebral abscess.

*A Case of Chronic Otorrhœa.*

This was a case in which careful and persevering treatment of a chronic otorrhœa by various lotions, antiseptic powders, and spirit "drops" had failed. The practical question therefore arose, What more can be done? Examination showed a perforation in the posterior superior quadrant of the tympanic membrane with pus oozing through it. These facts and the long history of obstinate discharge indicate in all probability caries of the incus. The next step in treatment therefore is to take away the carious ossicles. When the source of irritation has been removed the discharge will probably cease. In this case the radical mastoid operation need only be considered in the event of the failure of ossiculectomy.

*Syphilis of the Fauces.*

The question of the treatment of this condition arose in connection with a patient showing a well-marked erythema of the soft palate and tonsils. Dr. Tilley said that he rarely found topical applications necessary in secondary syphilis of the throat, as the condition almost invariably responds to general medicinal treatment. In the later stages of secondary syphilis, if ulceration should occur, local measures may find their place. One of the best of these is a solution of chromic acid (grs. x. to  $\frac{1}{2}$ i.). It is applied after carefully drying the ulcerated surface.

*Hæmorrhage after Tonsillotomy.*

A patient who attended with enlarged tonsils led to a discussion of the risks of hæmorrhage after the operation. In children it was agreed the danger is very slight. After puberty it is certainly a contingency to be reckoned with. Dr. Tilley advised the following measures for combating the complication:—(1) Seizure of the bleeding point by means of a long artery forceps in order to stop the hæmorrhage by pressure or torsion; (2) when no bleeding point can be seen, a styptic cream consisting of tannic acid  $\frac{1}{2}$ vi., gallic acid  $\frac{1}{2}$ ii., water  $\frac{1}{2}$ i., should be applied on a sponge, pressing this against the wound for a few minutes, and making counter pressure behind and below the angle of the jaw.

Among the other patients demonstrated was (1) a girl with characteristic adenoid facies; (2) a middle-aged man the subject of obstinate tinnitus.

## DISEASES OF THE EYE.

BY MR. MARCUS GUNN, F.R.C.S.

*Friday, October 18, 1901.**The Consequences and Treatment of Irido-Cyclitis.*

THE patient, a woman of 30 years, presented herself under the belief that she had a cataract in the left eye. Her visual power was much reduced, and at one part of the pupillary opening there was an opaque grey appearance which had led to the suggestion of cataract. Examination, however, showed that the case was not one of cataract. The pupil was seen to have a very irregular outline, and to be at several points adherent to the anterior capsule of the lens; oblique illumination showed that the grey opaque appearance was due, not to lens opacity, but to a layer of exudation partially occluding the pupil. By careful focusing a certain amount of haze could be appreciated deep in the lens substance where the absence of exudation left this accessible to observation. The patient had been under observation in 1896, when she had double iritis, and her present condition is a consequence of that attack. At the first observation there was noted the dotted deposit on the deep surface of the cornea known as *keratitis punctata*, showing that the inflammation was not limited to the iris but extended more deeply and involved the ciliary body. The condition then was one of irido-cyclitis, and the present state of matters illustrates the possible results of that disease.

Regarding treatment it is necessary to disappoint the patient in the hope that an operation will restore her eyesight. She is quite able to get about in her present condition, and any operation would not only fail to thoroughly remove the lens, but would run the risk of lighting up fresh inflammation in tissues which are more than usually prone to inflammatory disturbance. Later, should the state of the eyesight become more desperate, an iridectomy might be advised. This would have two advantages. First, it would by breaking through some of the adhesions which surround the pupil allow free circulation of fluid from the posterior to the anterior

chamber. As long as this is prevented there is a tendency for fluid to accumulate behind the iris, which is thus bowed forwards (*iris bombé*), causing a gradual increase of intraocular tension with a consequent risk of secondary glaucoma and optic atrophy. In the second place, a free iridectomy would allow the state of the lens to be ascertained. At present this cannot be done because of the layer of exudation on the anterior capsule. Should the lens be found transparent the fundus could then be examined, and if this exhibited structural changes—as it is very liable to do in any case of inflammation of the ciliary body—further operative measures would be useless. With a healthy fundus the iridectomy would improve the patient's eyesight, and would encourage an attempt to remove the lens should this subsequently become opaque. On the other hand, should the iridectomy discover a lens already opaque, it would have to be considered whether an endeavour to remove this should or should not be made. Such a proceeding might be undertaken on the chance of giving the patient some measure of eyesight, but it would by no means be devoid of risk. Secondary cataracts are somewhat intolerant of interference, and in such a case as the present there is the possibility—perhaps the probability—that the removal of the cataract will only reveal a retina the responsive power of which has been damped by inflammatory and degenerative changes.

The treatment of the patient at the onset of the irido-cyclitis had been the use of dark glasses, hot fomentations, and atropine ointment (grs. iv. to ʒi. vaseline). As she was anaemic iron had been ordered. There had been no evidence of syphilis or tubercle, and so for want of a better explanation the irido-cyclitis had to be labelled "catarrhal." Mr. Gunn spoke of the necessity of having ointments for the eye made with yellow, not with white, vaseline. In the preparation of the latter, owing to the methods employed, the vaseline has irritating qualities.

#### *Aseptic Routine in Ophthalmic Operations.*

In describing the operation of needling proposed to be performed on a patient having an opaque membrane after a cataract operation, Mr. Gunn related the precautions he adopts in reference to the

instruments to be used in any ophthalmic operation. They are as follows : The instruments are first boiled in a steriliser, each is then carefully examined with a lens with a view to detect any blood-stains or other gross evidences of contamination, and is rubbed clean with a fine handkerchief. After this the instruments are placed in a shallow operating tray with a 1 in 20 carbolic solution, then each one is dipped for a quarter of a minute or so in a solution of carbolic acid in absolute alcohol (1 in 3), and is restored to the operating tray. Now the conjunctival sac is thoroughly washed out with normal saline solution, a clean sterilised syringe being used. The 1 in 20 solution is drained off from the instruments, the last drops being removed by means of the syringe, and cold boiled water is poured over the instruments in the operating tray. With these precautions Mr. Gunn has never seen suppuration occur.

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## CASES WITH COMMENTS FROM THE SURGICAL CLINIC.

BY JONATHAN HUTCHINSON, F.R.S., LL.D.

(Continued from page 142.)

*Thursday, October 24.*

### I.—*Popliteal Aneurism.*

AN auction-porter aged 53. The left popliteal space was occupied by an elongated aneurism which beat strongly but had no bruit. No history as to its commencement could be obtained. He had discovered it five months ago, but had not sought advice until a week ago. It had recently extended and become painful. I remarked that it was a case calling for prompt treatment, as the structures over it were adherent, and it appeared to have made much extension downwards quite recently. There was fear that the sac might rupture and produce diffusion of its contents. It was not suited for flexion treatment, and on the whole I thought it best to advise immediate ligature of the femoral.

Dr. Westlake, who sent this patient, informed us that the man had had syphilis twenty years ago, and had suffered many attacks of true gout.

[P.S.—The artery has since been tied and the patient is doing well.]

*II.—Aggressive Hemiplegia with Recurring Attacks of Clonic Spasm in the Affected Limbs.*

A man aged 52, who brought full notes of his case from Dr. J. W. Smith, presented the condition of aggressive left hemiplegia with the history of repeated attacks of clonic spasm in the affected limbs. His face had wholly escaped. The history of his attacks, which he gave with much intelligence, offered some peculiar features. He had never in any degree lost consciousness. His first attack occurred one evening last July, without warning, and when he considered himself in good health. The left upper and lower extremity began to twitch, and continued to do so for half an hour. In the course of two or three days he had quite recovered, but since then several other similar attacks but less prolonged had occurred, and he had gradually lost power in the limbs. He could still walk and could grasp tolerably firmly with the hand, but he dragged the leg. When the attacks were coming on he was always able to get to a chair or couch, and had never actually fallen. He had had no pain in his head, and was never threatened with loss of consciousness though sometimes giddy. His optic discs were normal, hearing good, and knee reflexes vigorous. Although he denied having ever had syphilis it was thought that he had been benefited by mercury and iodides given during the last few weeks.

*III.—Inherited Syphilis in a young Girl whose Physiognomy was not Characteristic.*

A married woman attended with her eldest child, a tall well-grown girl of 14. The interest in the case centred in the fact that the girl, although unquestionably the subject of inherited syphilis showed but little signs of it. She was florid, and her physiognomy displayed no peculiarity excepting some fulness of the frontal eminences. Her teeth were white, and all of them, excepting the two upper central incisors, were well formed and regular. The pair of incisors were large and white, but they slanted away from each

other, were of screw-driver shape, and one of them showed a small but definite central notch. In corroboration of the diagnosis the girl had passed through a severe attack of interstitial keratitis at the age of 8, which had left a dense central cloud in the left eye.

I took occasion in connection with this patient to remark that the peculiar malformations of the teeth, which denote hereditary taint, are often by no means very conspicuous. It would have been easy in this instance to overlook them, and say that the teeth were good, whilst, to the trained eye, they were quite characteristic; I also asked attention to the fact that the girl, excepting for her attack of keratitis, appeared to have incurred no detriment from her taint. Further, it was interesting to note that her mother, who was before us, had suffered nothing. Her history was that her first conception ended in a still-birth; her second, a year later, produced our patient, and a few years later she had borne a son who was, she said, quite healthy. She herself had never ailed anything whatever, excepting, that latterly she had been liable to headaches. Her husband had enjoyed good health ever since she knew him, but he was now suffering from ulcers on the legs. He had been a soldier.

#### IV.—*A Case of Herpetiform Pemphigus.—Cure by Arsenic.*

(Dr. Corbet Fletcher's case.)

Our patient was a cab-driver of about 40 years of age, and the severe attack of dermatitis from which he was suffering had been present about a month. He told us, however, that he had been liable to such attacks in spring and autumn for several years, though he had never had one which had in the least approached his present condition in severity. On former occasions he had never sought advice, and had always been able to continue his occupation. But at the present time he was quite disabled, as the whole of his lower extremities were covered with crusts, excoriations, and ill-formed bullæ. Dr. Fletcher told us that he had in the first instance prescribed iodide of potassium, but having obtained no benefit had during the last week left it off and given arsenic, and under the latter he thought that improvement was already quite definite.

The man's legs were, however, still so much inflamed that he could not stand, and had to be carried everywhere. The general health had not materially suffered.

In the first instance I directed attention to the peculiarities of the eruption. It was symmetrical and it was confined to the limbs. Although far more severe on the lower extremities than the upper the latter were not free.

There were long oval groups of small vesicles and excoriations on the fronts of the arms from the shoulders to below the elbows. These were arranged somewhat in the herpetiform manner. The condition on the legs differed from that of the more common type of pemphigus in that none of the bullæ were perfect. They were in fact vesications rather than bullæ, the epidermis apparently breaking as soon as raised, and the process spreading infectively at the borders of each spot. The whole structure of the skin was involved in the inflammation to a much greater extent than is usual in typical pemphigus. In this feature, however, it did not wholly differ from the form of pemphigus to which the name *vegetans* is given.

The general aspect of the legs, however, was very suggestive of a locally infective process.

With a view to the determination of rational lines of treatment the foremost question which we had to decide was as to whether our remedies should be directed to internal or external causation. The symmetry of the arrangement, its restriction to the limbs, and the fact that the man had had previous attacks, all concurred to show that the eruption was due to some influence brought to bear upon his whole organism. Very probably from the fact that former attacks had subsided spontaneously the eruption was in some sense allied to herpes. We must refuse to allow our conceptions of disease to be restricted by the names which we use. Unquestionably there are forms of "herpes" which are in alliance with or introductory to forms of eruption which go by the name of "pemphigus." The dermatitis herpetiformis of Duhring is a sort of connecting link between herpes and pemphigus, and like the latter may be cured, or at any rate closely restrained, by the use of arsenic. The present case does not, however, at all conform to Duhring's type but comes, I fear, much nearer to that which results in pemphigus *vegetans*. In a very typical case of the latter disease (a portrait of which is in our Museum) the patient in which, a strong healthy man much like the subject of our present case, had been liable for many years to herptic attacks in his mouth which disappeared spontaneously.

He had also been cured of one attack of pemphigus before the disease finally settled into the more aggravated form which resisted all treatment and ended in his death. You will see that the recollection of such facts suggests a very serious prognosis for Dr. Fletcher's patient. Pemphigus vegetans when once the condition is well declared, although it may be influenced for good by arsenic, opium, and some other drugs, usually ends in death ; and one of the most distressing forms of death which it is possible to conceive. We have, therefore, every motive for being zealous in seeking for the right interpretation of the facts before us. I have no hesitation in recommending that in the first instance arsenic should be tried. With it should be combined small doses of opium, and if it does not manifest specific influence for good very quickly I would re-inforce it by full doses of quinine. The disease must be cured quickly or it will never be cured at all. Whilst placing our chief reliance upon internal medication, I do not think we should be justified in neglecting the possibility that the dermatitis may be itself attended by locally infective elements. In a general way we assert that herpetic secretions are not in themselves infective, and excepting for the use of soothing applications we leave herpetic vesicles to dry up and disappear of themselves, well assured that they will leave nothing behind them and that they have no power of self-perpetuation. We must not, however, venture to be too dogmatic where the interests of our patients are concerned. It would be well, therefore, in the present case that we should treat this patient's excoriations as if they contained infective elements.

We should secure the removal of all crusts and use parasiticides, tar, lead, mercury, for instance, in a systematic manner. No doubt Dr. Fletcher will let us see his patient again and we shall note with great interest the progress of a most important case.

(On a subsequent occasion I produced the portraits from the Museum which illustrate dermatitis herpetiformis, common pemphigus, pemphigus vegetans, pemphigus foliaceus, and other allied conditions.)

P.S.—Since the above was in type we have received the following report from Dr. Corbet Fletcher:—October 27, the patient improved rapidly under the influence of arsenic. He called on me a few days ago and was practically well, and able to resume his work.

COMMITTEE OF INVESTIGATION ON  
CLIMATOLOGY.

DISEASE AT MOMBASA.

MOMBASA is a small island on the East African coast north of Zanzibar, and but little south of the Equator. It is of very ancient repute as a commercial port, since it enjoys an excellent harbour, and is sufficiently distant from the mainland to be secure from attack. It is now connected by a bridge, from the foot of which, on the mainland, rises a railway, which passes inland for a distance of several hundred miles, and makes an ascent to the height of 6,000 feet into a country well suited for agriculture and gardening, and famous for its game. The island is the port of embarkation for this district, and is now, under English rule, again rapidly reassuming its former importance. It is of coral formation, and as such is flat. It is placed in the duplicate estuary of two rivers.

The following notes are the result of an interview with Mr. J. T. C. Johnson, who has resided for two years at Mombasa as Government Medical Officer in charge of the police, the jails, and other Government establishments. His experience has in these appointments chiefly concerned the male adult population, and not much women or children. There are two other medical men in the island.

*As to leprosy.*—"There are a few cases. I do not think that I have myself seen more than six or seven. There is no leper house. As to food they have plenty of vegetables, rice, &c., and also a good supply of mutton and goats' flesh. They catch a good deal of fish, which is eaten fresh. They also import from the gulf of Aden salted fish, chiefly shark, which they esteem highly as a flavouring for rice. You ask if I have myself eaten it. No, never; it smells disgustingly. No fish curing is done on the island. I have seen much more leprosy at Zanzibar."

*As to Yaws and Syphilis,* Mr. Johnson said that he had been much interested in what he had read in THE POLYCLINIC on the subject. The natives made a distinction between what they called

Buba (= yaws) and syphilis, but he himself had never been able to appreciate their distinction. He saw a great deal of syphilis, which he thought ran much the same course as in Europe. He believed that it was usually contracted by venereal intercourse. He had found it very amenable to the grey powder tabloids. The eruption which the natives called "Buba" very frequently leaves behind it deeply pigmented stains. Lupoid ulcerations were also common. At Lamu, a district on the mainland north of Mombasa, the natives had but one name for all the eruptions classed as syphiliis and yaws, calling them all "Buba." He thought that well characterised framboesial eruptions were rare.

*Tuberculosis* was, Mr. Johnson said, common in the island, more particularly amongst Somali people, but prevails also amongst the Swahili (the native race). Pleurisy is very common, and sometimes seems to spread as an epidemic.

*Bronchocele*.—Our informant had never seen a case, but on the Gold Coast (West Africa) he had seen many.

*Elephantiasis*.—Although many natives have the filaria in their blood, examples of severe elephantiasis are rare.

*The Chigoe* is now common, but Mr. Johnson thought less productive of ill consequences than when it was first imported.

*Fevers*.—All forms of malarial fever are occasionally observed. The "Blackwater" is seen chiefly in Europeans who have been travelling inland in the Nile provinces. He believes that both in Pemba and Zanzibar this form of fever has been newly imported.

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## REVIEWS AND NOTICES OF BOOKS.

TRANSACTIONS OF THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND. Vol. VI., pp. 75. Price 5s. H. K. Lewis, Gower Street.

THIS society was fortunate in having one of the foremost dermatologists of Great Britain as its president during the year concerned. The interest which Dr. Radcliffe Crocker has evidently felt in his work, and the part which he took in the discussion of almost every case which was brought under notice, have rendered this

volume especially valuable. The result is that it is one which everyone interested in skin diseases, and who desires to keep abreast with the knowledge of the day, should read through. This is no



*Multiple Carcinoma of Skin (Mr. Allworthy's case).*

heavy task, for it is but a small book, and the cases are very briefly put. Perhaps its chief fault is too great brevity. In not a few of

the important cases narrated more details could have been wished for. The editor's task has, however, been judiciously performed, and the records as they stand are of great value. Amongst those who, in addition to the president, have chiefly contributed to the success of the session are Dr. Abrahams, Dr. Eddowes, Mr. Pernet, Dr. Stowers, Dr. Savill, Mr. Hitchins, and Mr. Arthur Shilletoe. Mr. C. F. Marshall contributes an interesting example of the family form of pemphigus (*epidermatolysis bullosa familiae*), and Mr. S. A. Allworthy narrates, with an excellent photographic illustration, the history of an almost unique form of malignant growth, the histology of which is described by Mr. Pernet. By the courtesy of the Council we are enabled to reproduce here this portrait. The case was that of a man aged 55, in whom the tumours had been growing for eighteen months. Some had disappeared spontaneously and others had been cut away, but many new ones had appeared. The disease was still local, but the man was emaciated and the inguinal glands were much enlarged. These facts, taken together with the results of Mr. Pernet's histological examination, led to the diagnosis of multiple alveolar carcinoma.

Amongst those who have made valuable contributions to the discussions, but have not themselves brought forward cases are Dr. Bowles, Dr. Galloway and Dr. Campbell Williams.

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#### CATALOGUE-COMPANION TO THE MUSEUM.

##### DISEASES OF THE SKIN IN CONNECTION WITH TUBERCULOSIS.

ONE of the most valuable, as well as most extensive, of the divisions into which our Museum naturally separates itself is that which concerns the Tuberculous Affections of the Skin. It is exceedingly difficult to assign the limits of this group. Modern research has very much extended them, and if we rightly judge of its tendencies will the future widen them yet more. The attempt to classify into tuberculous affections and "tuberculides" and to assume that the former are due to the presence of the bacillus, and the latter to that of its toxine, is for the present so purely a matter of conjecture that

the clinical observer had better leave it wholly aside. For our present purpose it will be safest to take together all the various affections which can be reasonably supposed to be in any kind of association with tuberculosis. We must see where these forms of dermatitis are to be severally allotted by mutual affinities and divergencies, and must trace out connecting links where such can be discovered. To this task a large collection of pictorial illustrations, taken from all available sources affords most valuable assistance.

A large series of original drawings constitutes the basis of our collection, but it has been supplemented by others selected from all available sources. Quite recently it has been enriched by the addition of those contained in Professor Kaposi's Hand Atlas and in the folio one published by Radcliffe Crocker and those given in the Atlas selected by Dr. Pringle from the St. Louis Hospital Museum. The illustrations from these three sources furnish admirable material for international comparison, not only as to the conditions observed, but as to the terms employed for their designation. The value of Kaposi's portraits, which are very numerous, would however have been immensely increased if they had been accompanied with brief case-narratives.

It is not an easy task at a juncture when much of our knowledge is still under debate to make a satisfactory classification of the affections of the skin which occur in connection with tuberculosis. Year by year fresh facts are obtained demonstrating the presence of the bacillus itself in conditions under which previous investigators had failed to find it. We shall be on fairly safe grounds if we take infective spreading; chronicity; a frequent coincidence with other scrofulous manifestations, either in the patient or in relatives; and the destruction of tissue; when occurring together and in the absence of other obvious causation, as implying grave suspicion of tuberculosis. Keeping these features clearly in view we may perhaps suitably arrange our portraits into the following natural groups:—

(I.) Tubercular ulcerations of the skin not preceded by any of the more obvious changes designated as Lupoid.

(II.) Ulcerations of the skin secondary to indurations in the cellular tissue attended by erythema ("Bazins' Malady") the Erythema Induratum of the scrofulous of Bazin.

(III.) Lichenoid Eruptions. The Lichen Scrofulosorum. Our portraits coming under this head have been already described.

(IV.) The various affections to which the term "Lupus" is applicable. These it will be best to place in one large family, divided, not too abruptly, under the time-honoured designations of Vulgaris and Erythematosus. With them will find a place various minor type-forms, the peculiarities of which must be explained as we proceed.

(V.) Certain infective diseases of the skin attended by conspicuous lymphatic and angeiomatous changes.

(VI.) Lupoid affections of the skin, which derive peculiarity from the fact that they occur in those who have suffered from syphilis. (Syphilitic Lupus.)

Premising that the paramount object of our Companion-Catalogue is to make the collection intelligible and useful to those who visit it, we must ask the reader's indulgence if he should find the following rather lengthy descriptions of portraits somewhat monotonous reading when undertaken apart from the objects to which they refer. Our hope is that they will lead him to consult the Collection with our Catalogue in hand.

### *The Lupus Family.*

We shall of course adhere to the generally accepted division of the lupus family into two large groups as Vulgaris and Erythematous. It will be necessary, however, repeatedly to insist that it is not always possible to definitely assign a given case to one or the other category, and that there are numerous pathological conditions which partake of the qualities of both. The words, indeed, although exceedingly useful for practical purposes, and although conveying distinct and well recognised conceptions of very important differences yet do not designate species, but rather modifications of form. Of these modifications there may be great variety, for the pathogenic elements which conduce to them may be mixed in various proportions.

A not unimportant hypothesis will dominate all our attempts at the classification of lupus cases. It is that the histological processes with which we have to deal are the result of symbiotic union of the tubercle bacillus with the special cell-elements of the structure in which the disease begins. It is under this law that each specialised form of tuberculous disease of the skin — retains

for the most part its initial type. Under it lichen scrofulosorum continues throughout the same disease, lupus vulgaris remains vulgaris, and does not assume the type of erythematous, and so on for the rest. The elements which in each form of disease give the process its infective or serpiginous character are neither pure bacilli or their toxin, but the result of union of these with the cells of the tissue involved. The rôle of the bacillus or its toxin is to stimulate to morbid growth the tissues of its host, and by no means merely to multiply itself. Thus the lupus-process resolves itself into a form of chronic dermatitis set going by the bacillus, but with the special form of which the latter has but little to do. The form and type are given by the tissues themselves. A secondary law—concerning which little need here be said, but which it is necessary to recognise if we would obtain a clear comprehension of the facts—is that there is in the process of self-infection an elective preference for structures of the same character as those in which the process has originated. Thus if the process has begun in glands it will preferentially infect glands; if in the perivascular tissues it will keep to them, and so on.

Not perhaps the least useful purpose which the grouping and classification of a large number of Lupus portraits may serve will be to give clearer insight into the meanings which are to be attached to the names which authors have used. It may, perhaps, lead to a considerable simplification in our nomenclature. Adjectives have been applied which, in many cases were superfluous at the time and in others have become so by the advance of knowledge. Nor are the older writers alone open to this criticism. Some of our best and most recent authorities are not wholly free from the accusation of using adjectives in an easy-going and somewhat thoughtless manner. These failures in precision come out clearly when two or more portraits illustrating clearly the same thing are placed side by side with differing designations.

#### *Lupus Vulgaris.*

The designation *lupus vulgaris* is applicable to those forms of tuberculous dermatitis in which there is a tendency to develop in the meshes of the corium a soft, semi-transparent granulation-substance which has been aptly compared to apple-jelly. In proportion to the abundance and definite character of this substance does the designa-

tion become indisputably appropriate. In this substance giant cells and tubercle bacilli have been repeatedly identified. Various clinical features are, in addition, associated with the accepted description of the vulgaris type of lupus. There is a tendency to infiltrate the more superficial layers of the skin and to produce soft tubercles which under unfavourable conditions inflame and ulcerate. When ulceration occurs it is attended almost invariably by the growth of granulation-papillomata which project into the overlying crust. These are torn whenever the crust is peeled off, and hence the observation that you cannot clean a patch of lupus vulgaris without making it bleed. It is an invariable condition of lupus vulgaris that its borders have an infective propensity and tend to advance into the adjacent skin (contagion of continuity), and that very frequently this process of infection occurs at little distances from the parent patch, and what are termed "satellites" are produced.

*(To be continued.)*

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## CORRESPONDENCE AND ANSWERS.

SEVERAL correspondents have addressed us in reference to the vaccination of syphilitic subjects. Their questions refer in some instances to different stages of the disease. One enquires whether a man who has had syphilis ten years ago may be vaccinated without risk of ill result. He fears the formation of a lupoid gumma or enlargement of the glands. The risk of such occurrences is infinitesimally little, and may be wholly ignored. The question as to those who are in the secondary stage is perhaps of not much greater importance. At any rate it is quite certain that vaccination in such cases usually runs its normal course and is neither affected by nor affects the existing taint. The vaccinator must, of course, be extremely careful as to his instruments. As to infants suffering from inherited taint the same opinion may be given. They go through vaccination well.

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DR. HAVILAND, in his work on the "Geographical Distribution of Disease," insists that strong wind is very prejudicial to the subjects of phthisis. He more especially refers to wind from the sea coming over low shore-land. If there is a steep cliff the sea wind is deflected upwards to a great height and the districts above the cliff are protected. He instances the country about Scarborough as being thus protected and says that it has a low mortality from phthisis. On the east coast of the north of England the opposite condition prevails and phthisis is prevalent.

EXCESS IN COFFEE DRINKING.—Honoré de Balzac is recorded to have died of “over brain-work and the excessive use of coffee.”

\* \* \*

*To the Editor of THE POLYCLINIC.*

“ Calcutta,  
September 2.

“ SIR,

“ May I correct a small error on p. 54 of the August number of THE POLYCLINIC. In the interesting note on “The Chigoe in Africa” the statement is made that “as yet the jigger has not reached Madagascar or India.” As to Madagascar I know not, but it is a fact that the chigoe has certainly reached India. It probably for the first time reached India and Aden (therefore also Arabia) in the steamer *Canara*, which conveyed back to India the 4th Bombay Infantry from British East Africa in December, 1898. Capt. P. P. Kilkelly, I.M.S., M.B., the medical officer of that regiment, reported on the jigger and its dangers, and the Government of India published the information. Numerous allusions to the jigger will be found in the *Indian Medical Gazette*, vol. xxxiv.—for 1899—pp. 147, 160, 173 and 458. The large number of Indian coolies who have gone to work on the Uganda Railway have rendered it inevitable that the flea should be introduced; so far as I am aware, however, the disease and the flea have not become acclimatised in India.

“ Yours &c.,

“ W. J. BUCHANAN, M.B., Major, I.M.S.”

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*To the Editor of THE POLYCLINIC.*

“ Kilburn Dispensary,  
“ 13, Kilburn Park Road,  
“ October 30, 1901.

“ DEAR MR. EDITOR.

“ In the interesting account you give of my case of “Sprengel's Shoulder” in the September Number of THE POLYCLINIC you apparently do me the honour of having discovered its proper nosological label. I wish, therefore, to say that I was entirely indebted for the diagnosis to my friend, Dr. G. Sutherland, Physician to the Paddington Green Children's Hospital. If you could find room in the next issue to take notice of this correction you would greatly oblige

“ Yours very truly,

“ TRAVERS SMITH.”

\* \* \*

INSUSCEPTIBILITY TO VACCINE.—A young woman puts to us the following question: “I have been vaccinated fifteen times up till a very few weeks ago, when I was vaccinated for the sixteenth time. It has never taken, nor have I got one mark on my arm. I should feel obliged if you would kindly let me know if I ought to be re-vaccinated, or if I am properly protected?”

The advice which we have given to our correspondent is that if she has not yet tried arm to arm vaccination it should be done, and not later than the seventh day. We have suggested that possibly, although it has left no scars, her first vaccination in infancy may have been effective. Lastly, that if all the vaccinations have really failed she cannot consider herself safe from small-pox, and should carefully avoid the risk of contagion.—ED.

# THE POLYCLINIC

BEING THE

JOURNAL OF THE MEDICAL GRADUATES'  
COLLEGE, LONDON.

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VOL. V., No. 6.—DECEMBER, 1901.

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## OUR CORRESPONDING ASSOCIATES.

THE following suggestions have been compiled in response to requests from several of our Corresponding Associates to be informed as to the subjects upon which we desire their observations. It will be obvious that they are only fragmentary, and that they do not deal with more than a small portion of the topics which might be mentioned. We have, however, selected some of those which seem to us of most importance at the present time. Some of them concern diseases which are scarcely, if at all, known in England; and others, those which may be met with all over the world. Observations respecting many of the latter, conducted abroad and under conditions widely different from those which obtain at home, may become very valuable in their bearing upon British medicine. They may help to correct false impressions as regards etiology and predisposing influences, or may confirm true ones, or perhaps suggest new lines of enquiry. Thus the study of the geographical distribution of disease is of great interest to English practitioners as well as to those residing abroad. In submitting the following suggestions to our readers we would venture to insist strongly on the importance of careful accuracy and of sufficient detail. The publication of mere opinions, or of impressions formed on superficial observation, is of little use, and may even

be misleading. In not a few of the subjects mentioned our literature is already over-loaded with unverified and often contradictory statements. This was unavoidable in times not long past, but it is year by year becoming less excusable.

Hirsch's Handbook should be the Bible of the medical observer in foreign parts. In it he will find excellent summaries of what is already known on most of the subjects to which we refer, and abundant illustrations of the remark which we have just ventured to make.

With a view to verification, not only should the notes of cases be full, but wherever suitable, photography should be employed. Our arrangements at the Polyclinic enable us to arrange and classify all pictorial illustrations of this kind which may be entrusted to us, and a similar statement may be held to apply to all manuscript communications.

#### *Cancer and New Growths.*

The prevalence of NEW GROWTHS, whether innocent or malignant, is a subject worthy of observation and record. The opinion is probably well founded that cancer is rare amongst uncivilised races, and facts are wanted as to whether this is true of all such races. Also we want to know whether the non-malignant forms of neoplasm are infrequent in equal ratio with the malignant. In order that we may have data for a possible explanation of the rarity of new growths we need to have some estimate of the average longevity of the race concerned and also of the usual age of parents at the time of the birth of their children. A suspicion prevails that children born to middle-aged parents, and especially those to senile fathers, are more prone to cancer than the children of the young. There is some plausibility in this since the tissues of middle-aged persons are certainly more liable to cancer than those of the young. It is presumable that amongst uncivilised peoples the average age of parents at the time of the birth of their children is much younger than it is under our modern conditions of social life. This, however, needs to be corrected or verified by observation on the spot.

#### *Arthritic Maladies.*

GOUT AND RHEUMATISM, and the various forms of intermediate disease, are subjects which offer in different directions lines of

enquiry of great interest. It is asserted that true gout occurs amongst the millet-beer-drinking Kaffirs, and we have recently in our "Correspondence" asked especially for information on this point. Probably gout is very rare, or unknown, in most communities not advanced to the very foremost rank in civilisation. We must not, however, take this for granted, and of those who are so advanced we have many communities concerning which information is wanted. We may take attacks of podagra as supplying the final and indisputable test of the diagnosis of gout. Now respecting the whole of Europe it would be of the utmost interest to know what the relative number of those liable to such attacks really is. Information on the same subject is desirable from the two Americas, from Japan, China and India. Side by side with it should be recorded an estimate of the prevalence of the different types of rheumatic gout and of uncomplicated rheumatism. It is obvious that the relationship of these with true gout will be most instructively illustrated by what can be ascertained as to their coincident prevalence. Facts of much value in these matters may be obtained not only from observation of living patients but by enquiry in pathological museums, wherever such exist. Our British and Irish museums abound in specimens of gout and rheumatic arthritis, and so far as their evidence goes it would seem that these two diseases prevail together. It would be of the utmost interest if those who have access to museums in other parts of the world would carefully examine the specimens and report as to their character and number.

### *Leprosy.*

Wherever LEPROSY occurs careful estimates should be formed as to the number of cases in ratio with population and as to the races or social classes in which it prevails most. As little as possible should be taken on hearsay evidence, and wherever possible the facts should be authenticated by personal observation. In all cases in which the diagnosis is open to doubt it should be so stated. Enquiry should be made of the patients themselves as to their own impressions as to how the disease had been acquired, and of course their family history should be taken. Lastly there should be a careful statement as to articles of food, and more especially as to dried or salted fish.

*Syphilis.*

It is of course important to estimate everywhere the prevalence and the special features and character of SYPHILIS. In many countries it may be of interest to examine the native traditions as to its introduction, and to note the derivations of the names by which it is known. In Fiji we appear to have an instance in which from time immemorial the greater part of each successive generation has passed through syphilis in childhood. Thus a very peculiar condition of things has been produced. Tertiary phenomena are very common, inherited disease very rare, and venereal contagion so rare that it has almost wholly ceased to be recognised. Are there other countries where some approach to a similar state of things has been attained? Our correspondent's letter from Pemba (see p. 157) would suggest that in that island it has, and some of the facts as to Ceylon may imply the same to a partial extent. Wherever any conditions are recognised under the name of "Yaws," there according to modern opinion non-venereal syphilis prevails, and young persons are attacked. But further observations are needed before this can be regarded as an established fact. Wherever "Yaws" is diagnosed the peculiar features of the eruption should be described, and its concomitants noted, more especially the state of the throat and mouth. The influence of mercury in the native races on both "Yaws" and Syphilis given carefully in very small doses, and long continued, should be recorded.

*The Exanthemata.*

The presence or absence of the Exanthemata and of Diphtheria and the various forms of Fever should be recorded.

*The Cryptogamic Diseases of the Skin.*

The Cryptogamic forms of Skin Disease—the Tineas—should be noted. *Tinea Versicolor* will probably never be seen in those who do not wear clothes on the bust, and its frequency will be in ratio with the habit of wearing woollen clothing night and day. Are cases of Favus ever seen in communities where house-mice are unknown, and is ringworm, where it occurs, equally common in calves and children? Do cases of the tropical *Tinea imbricata* occur? Are typical examples of *Alopecia areata* common?

*Herpetic Maladies.*

The whole family of HERPETIC MALADIES may also offer opportunities for fruitful investigation. Is common shingles an affection of universal distribution? Our Museum does not contain a single illustration of it on a dark skin, and some photographs would be very acceptable. In malarious districts the symptomatic forms of Herpes which so often result from a rigor might be expected to be very common. Are they so? Is arsenic extensively used for Intermittents, and if so does it ever produce Shingles?

(*To be resumed.*)

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## SYPHILIS IN THE TROPICS AND ITS TREATMENT.

THE letter which we published in our September issue<sup>1</sup> from a Missionary Correspondent at Pemba (Zanzibar) is of interest in more than one direction. In the first place it makes it clear that there occurs on the east coast of Africa a malady in all respects similar to the "Yaws" of Ceylon and the West Indies, and the "Toko" of Fiji. Mr. Finucane's communication to our Investigation Committee<sup>2</sup> on the last named locality has probably convinced everyone that the aboriginal malady so named, and so long considered as distinct from syphilis, is really none other than the framboesial type of that disease. It would be premature to say that all are convinced that the West Indian and Ceylon disease are of the same nature—but it is perhaps only premature. Additional evidence is likely to accumulate rapidly and the question will soon be set at rest.<sup>3</sup> Meanwhile it is important to note that a severe type of disease, which most surgeons on the spot call syphilis but which in many instances presents all the supposed peculiarities of "yaws," is terribly and increasingly prevalent in Africa. To this fact many missionaries and other observers bear testimony. We have received communications on the subject from many widely distant localities — Basutoland,

<sup>1</sup> See p. 157.

<sup>2</sup> See p. 157.

<sup>3</sup> Since this was written Dr. Simpson has remarkably confirmed these statements as applicable to the natives in Cape Colony (see our next Number).

Nyassaland, Zanzibar, Madagascar, &c. It is spoken of as the curse of these countries, and as almost universally prevalent amongst the natives. It occurs as a family disease spreading by accidental contagion, and is by no means exclusively, nor even commonly, venereal in origin. Thus, as our Pemba correspondent states, children are very frequently its subjects. Hence the primary sore is most frequently overlooked. Very similar statements are, we believe, applicable to India and other tropical countries where Europeans and natives come into contact.

It becomes, therefore, of great importance to consider what are the best means of treatment which should be adopted. In many cases those upon whom the responsibility of the treatment will devolve are missionaries who have not had a complete medical education, and it is consequently essential that the rules laid down should be explicit.

The treatment of syphilis in the tropics ought probably to differ less from that pursued in England than is generally supposed. It is often suggested that mercury is not so well borne, but this is perhaps because it is not judiciously given. The old errors of large doses and irregular and interrupted courses are still too often perpetrated. If it were the rule to give only the *hydrargyrum cum cretā*, and in doses of never more than one grain, we should probably hear but little of disagreement. Keeping to that dosage the frequency of administration may be modified according to effects. Almost the only inconvenience to be feared is diarrhoea, and that should be met by strict rules of diet and by the liberal use of opium. The latter is a remedy which, in the dark races, usually suits well, and given in medicinal doses of a sixth or quarter of a grain three or four times a day, there is little or no risk of inducing a fondness for it. Usually much smaller doses will suffice, but it should be given with sufficient liberality to absolutely prevent diarrhoea. As to diet, all green vegetables, all fruits, and all soups and broths, should be forbidden, whilst milk, rice, potatoes, and any kind of solid meat or fresh fish may be allowed. The addition of quinine to the mercurial pill is probably an advantage in all cases of syphilis treated in the tropics. It goes admirably well with mercury and opium. The mercury prevents the other ingredients from disagreeing and obviates what used to be called "locking up the secretions." It keeps the liver going,

and many persons with whom either quinine or opium would disagree alone take them with advantage when combined with mercury. For general use in the tropics a pill containing a grain of hydrargyrum cum cretâ, a grain of sulphate of quinine and a fifth of a grain of opium cannot perhaps be surpassed. It should be given three times a day at least and increased to four, five or six times if needful. Under its influence the patient will usually recognise that not only do his syphilitic manifestations disappear but his general health improves. He will declare that he was never so well in his life and will be in no hurry to leave off his pills. When all symptoms have vanished, three times a day will be sufficient, but this frequency should be persevered with for at least twelve months from the date of its commencement. There should be no intermissions.

In tropical syphilis the eruption appears to be particularly prone to assume a suppurative or granulomatous form (framboesial) and for this local treatment is desirable in addition to internal medication. An ointment containing a scruple of white precipitate and the same of calomel to an ounce of benzoated lard is probably one of the best. If the sores ulcerate or become rupial then it may perhaps be well to substitute ointments containing ten grains of iodoform or the same of chinosol to the ounce. The mercurial one just suggested will in nineteen cases out of twenty suffice. It should be freely used and the careful removal of all crusts should be insisted upon.

The risk of ptyalism with the doses suggested, and if begun with caution, is not great. It is undoubtedly increased by the use of the calomel ointment, and this must be kept in mind. It is quite possible, if the eruption be plentiful and the ointment applied freely, to salivate without any administration by the mouth and, of course, at the same time, to induce full mercurial influence on the system. It is needless to say that all ointments should, in hot countries, *be freshly made* on the spot. The ingredients mentioned are, however, simple and easy to be both provided and employed. It would be well for all practitioners going abroad to take good supplies of the pills.

The inunction treatment of syphilis is exceedingly inconvenient amongst natives, and that by hypodermic injection is more or less dangerous even in skilled hands.

For the tertiary affections iodoform externally and iodide of potassium with ammonia internally are the remedies. Tropical needs and those of Europe do not differ as to these drugs. It is rumoured that this is so well known in Fiji that the iodide is imported "by the ton" for the relief of the periostitis of "Yaws."

J. HUTCHINSON.

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### THE FISH HYPOTHESIS OF LEPROSY.

WE inserted a few months ago, with a special object in view, a quotation sent us by a correspondent which seemed strongly adverse to the supposition that leprosy is caused by eating fish. The extract in question referred to Leprosy in Palestine. It was to the effect that the disease there occurred inland in regions where little or no fish was to be had. Our object in giving renewed publicity to this argument was in order to refute it, and to explain what the position at present taken by those who hold to the fish hypothesis really is. Briefly, it may be said that they by no means suspect all kinds of fish, and that they do not hold that a large consumption of any one kind is essential to the result. The kind of fish food under chief suspicion is dried or imperfectly salted fish. Fish in one of these conditions is often imported inland. It is light, indestructible, and easy of carriage; and it is in great request as a condiment whenever the supply of fresh meat is deficient. Especially is it valued wherever rice is largely eaten. Under many circumstances it is eaten in conditions of decomposition which would render it very repulsive to most European palates. It is an article respecting which great differences of taste may prevail, of which an individual or a family may become fond, and may consume much more than an average allowance. It is suspected that fish food of this kind, uncooked, may either carry the bacillus itself or may be the stimulant which excites it to action. Some would even go so far as to suggest that it may perhaps transmute the tubercle bacillus into that of leprosy.

It is evident on this explanation of the hypothesis that there is nothing to confute it in the fact that leprosy may be found in regions at a great distance from seas or rivers, and amongst com-

munities in which fresh fish is not an ordinary article of consumption. The question is not do they eat fish largely, but do they eat raw salt or dried fish at all. If the fish hypothesis be true, it is quite certain that it is not necessary that the quantity taken should be large. In fishing districts, where the fresh article is abundant, it may easily be the fact that very little is eaten in the dried or salted state, whereas the reverse may be the fact in others. There are many regions under similar conditions to those which prevail in Palestine, where dried fish is unquestionably obtainable, though not probably very largely consumed, and in most of these, as in Palestine, leprosy is an infrequent disease. It may also be asserted that it occurs chiefly amongst the poor who would be likely to get the worst kinds.

The hypothesis that leprosy is in some way connected with the eating of fish in an uncooked and often decomposing state, is attractive on account of the number of facts as to the malady which it appears to explain. Perhaps it ought not to count for much, but still for something, that it is absolutely the only one in the field. No one can assign any other plausible conjecture as to why a disease which is identically the same in all races, should prevail all over the world, and should have done so from the earliest periods of history, being apparently indigenous in the most distant places and under the most dissimilar conditions. No other article of food is of universal consumption. The theory that contagion explains its prevalence is confuted by its universality, its very limited incidence in many districts, and by a multitude of other facts.

Amongst the facts which, together with many others, the uncooked-fish theory of leprosy fits well with, we may mention the following :—

It would well explain the manner in which leprosy cases occur in countries where there are but few, that is, sparingly scattered often over a wide area. We have but to suppose differences in personal taste as regards dried fish and in facilities for obtaining it.

It fits well with the European prevalence of leprosy during the ascendancy of Roman Catholicism and with its decline subsequently.

Its absence in the interior of Russia at a time when it was abundant in Eastern Europe is explained by the fact that the fasts of the Greek church forbid the use of fish.

Its almost universal prevalence amongst aboriginal communities when residing where fish food is accessible.

Its not very infrequent development in strangers who have resided for only short periods in leprosy districts and have never mixed with lepers.

The occurrence of outbreaks coincidently with the establishment of fish-curing factories, *e.g.*, at the Cape and in the Sandwich Islands.

Its gradual disappearance from many countries simultaneously with improvements in the supply of other articles of food and the comparative disuse of fish.

The occurrence of isolated *de novo* cases under conditions which exclude all suspicion of contagion.

That no community can be named in which badly cured fish is largely consumed in an uncooked state in which leprosy does not occur.

That the dearth of salt (India), and the absence of fuel (Iceland and some parts of Norway), often appear to influence its prevalence.

The chief objections to the fish hypothesis may be stated to be:—

Its non-occurrence at the present day amongst many communities which yet consume fish freely. In reply to this it may be admitted that if sporadic cases did occur more frequently in non-leprosy districts, and if these could be traced to salt-fish eating, the hypothesis would be strengthened; but a fair answer to the objection is that the fish which is now consumed in civilised communities is either fresh or well cured and that it is usually well cooked.

Its occurrence in many inland communities who do not consume any large quantity of fish. This objection has usually been urged in forgetfulness of the fact that it is not the consumption of large quantities which is under suspicion but of small quantities of a bad kind.

The fact that some individual lepers will deny that they have ever tasted fish. This kind of evidence comes almost solely from India and is given chiefly by those who by religious creed are forbidden to eat it. In many instances it may have been that the enquiry was not made definite as regards fish-condiments and dried fish, and it may have been in some others that the reply was not a truthful one.

## SELECTIONS FROM CLINICAL LECTURES DELIVERED IN THE COLLEGE.

### ALCOHOL AS A FACTOR IN THE CAUSATION OF DISEASE.

[*Abstract.*]

PROFESSOR G. SIMS WOODHEAD, M.A., M.D.

THE pathological changes produced in the tissues by the action of alcohol is a subject of scientific interest which may be discussed entirely apart from the arguments that deal with the social use of alcohol as a beverage. These changes may possibly be quoted in opposition to such usage, but to the pathologist they present themselves primarily as facts of observation which have to be recognised and classified.

Introduced into the alimentary canal alcohol is rapidly absorbed, and is carried, by means of the circulating blood, to the various parts of the body, where it comes into contact with the several tissue elements. The promptness with which it is absorbed and diffused means that it reaches the tissues practically unchanged, and these are therefore exposed in the first place to the action of alcohol in an essentially unaltered condition. At a later stage the alcohol becomes oxidised, and this process when it commences proceeds with considerable activity. Each of these facts has its own special influence in determining the variety of tissue changes that are to be placed to the debit of alcohol as an agent competent to produce pathological disturbances in the bodily structure and functions.

The effects of alcohol on the protoplasm of the tissues may be conveniently studied in the cells of the central nervous system. Here it can be demonstrated that early and definite changes occur, both in the body of the cell and in its dendritic processes. The fine,

delicate filaments of the latter become obtuse and nodulated. In the cell-mass itself the Nissl bodies gradually lose their prominence and disappear, the cell substance becomes swollen, the nucleus indistinct, and the nucleolus abnormally large and conspicuous. These changes are not peculiar to the action of alcohol. Practically identical alterations are caused by the waste products which accumulate in the lymph spaces as a result of cell activity. And the same is true of the influence of various toxins, such as those which are produced in diphtheria, tetanus, etc. It is thus a matter of actual demonstration that alcohol exerts a prompt and definite toxic influence on nerve-cells, and presumably, therefore, also on the other functionally active cells of the body.

A second result of the continued action of alcohol is seen in connective tissue. Various poisons, it is known, when circulating in the blood, produce changes in the cells lining the capillaries. Alcohol in addition appears to stimulate endothelial cells around the small blood-vessels, with the result that these cells undergo proliferation. The new cells are of the hyaline mononuclear type; subsequently they become elongated and appear to form a periplast, and in this way new fibrous tissue is produced. This explains the so-called cirrhoses which mark the course of chronic alcoholism, and as alcohol when absorbed from the alimentary canal is conveyed by the portal vein directly to the liver, it is easy to understand why this organ is so frequently and in so marked a degree the site of cirrhotic change. Similar effects may be frequently detected in other organs and are common in the blood-vessels. There is, indeed, good reason to believe that alcohol may, by itself and apart from other influences, be responsible for a widespread arterio-sclerosis.

A third and very common expression of the action of alcohol is found in the form of fatty changes in the tissue-cells. This is often detected as a granular condition in the nerve-cells of the cerebral cortex in chronic drunkards. Fatty degeneration of the cardiac muscle is also a frequent and decided event. But it is more especially in the liver that fatty changes attain their most prominent degree. There are two different methods by which alcohol may bring this about. (1) As already stated alcohol at first reaches and acts on the tissues unchanged. Later it undergoes chemical meta-

morphosis, and the early products so formed have an intense chemical affinity for oxygen. They therefore utilise the oxygen of the haemoglobin. Now the hepatic cells contain as one of their normal constituents a certain proportion of fat, the fate of which in healthy metabolism is to undergo a gradual process of oxidation. But as the products of the decomposition of alcohol capture more or less of the oxygen of the blood there will be an insufficient supply to conduct the normal process of fat oxidation in the liver. Hence there results an accumulation of fat globules in the hepatic cells. An argument in support of this view is obtained from a study of the conditions in which fatty degenerations occur in the heart. One of these, as already mentioned, is chronic alcoholism. Another is leucocytæmia. In the latter, the great deficiency of red corpuscles necessarily means a defective supply of oxygen to the tissues, and restricted oxidation processes. In these circumstances fat accumulates in the cardiac muscular fibres. It is reasonable to suggest that alcohol, being an agent disposed to annex the haemoglobin oxygen, may also lead to fatty change by diminishing the opportunity for tissue oxidation. (2) A further result follows, viz., the breaking down of the proteid of the hepatic cells into fat, the cells themselves becoming shrunken. This always happens when alcohol has been taken in large quantities, and it may be an early occurrence when the cells have previously been weakened by the operation of some prejudicial influence. It is a change of a most serious nature, for when once developed it almost invariably means that the cells affected will never regain either their functional value or their histological integrity. Both in the liver, and to a less marked extent in the heart, it is common to find the influence of alcohol displayed in the shape both of fatty infiltration or degeneration of the parenchyma of the organ, and of cirrhotic changes in the supporting connective tissue. As it is in part excreted by the kidney, alcohol may here also produce cloudy swelling or more conspicuous fatty degeneration of the epithelium lining the uriniferous tubules, and in time also fibrosis of the inter-tubular fibrous tissue.

There is one effect of alcohol on the superficial blood-vessels which is of possible therapeutic importance, more particularly in the treatment of bronchitis. In this disease, especially in the acute

form, the blood-vessels immediately below the basement membrane on which the epithelium lining the bronchial tubes is supported, are abnormally dilated. Now the action of alcohol is to aggravate this dilatation, and it is thus reasonable to consider whether it is wise, as a matter of practical therapeutics, to administer an agent possessing the capacity to exaggerate a condition which is one of the existing features of the disease. There are yet other aspects of the influence of alcohol bearing upon the discussion of its position as a therapeutic agent. This is illustrated for example by the effects produced on the function of the heart, even apart from appreciable organic changes. One of the most important of these is that ventricular systole is rendered incomplete. In health the contraction of the cardiac muscle ensures at each systole the practical obliteration of the ventricular cavity. The ventricle is thus completely emptied of blood, and a firm muscular mass is contracted under the aortic (or pulmonic) valves, lending mechanical support to these under the strain of the superincumbent column of blood. But under the influence of alcohol ventricular systole is not quite complete. The ventricle is not entirely closed. A certain mass of blood remains, and thus increases the diastolic pressure. Further, the imperfect systole means that the muscular wall of the ventricle is not brought into a position where it can render effective support to the semilunar valves. Hence under repeated strain these may yield to an extent sufficient to permit some measure of regurgitation. The regurgitant stream falling upon the ventricular wall during diastole takes the muscular tissue at a disadvantage, and dilatation of the cavity of the ventricle is an inevitable sequence. All this, it is to be noted, is independent of any structural alteration in the cardiac muscle, but when, as sooner or later is certain to occur, fatty degeneration of the muscle develops, the conditions which favour dilatation are greatly increased. Another effect of alcohol which bears upon its therapeutic use is the modification which it produces in leucocytic activity, leading possibly to diminution of the resisting power of the tissues to disease-producing agencies. It is certain that resistance to some of these agencies depends on the multiplication, and on the regular order and sequence, of certain forms of leucocytes. Under the influence of particular toxic forces numerous polymorphonuclear cells make their appearance, to be succeeded

in a few days by mononuclear cells. The former have for their function the apprehension and inclusion of toxic agents, the cells and their included products being in time absorbed by their mononuclear successors. Anything which disturbs the activity or time relations of these processes may seriously weaken the sum of bodily resistance, and it is probable that this is the explanation of the fact that in certain animals alcohol renders the tissues more susceptible and yielding to such diseases as hydrophobia, anthrax, erysipelas, and pneumonia. All these are considerations which must be borne in mind in an endeavour to fix the therapeutic value of alcohol. Whatever advantages it may have, as for example by dilating peripheral arterioles and lowering arterial tension, it must be remembered that along with these there are certain risks and penalties. And it becomes a question whether these not unimportant qualifications do not, in many instances, more than outweigh any benefits which may legitimately be placed to its therapeutic credit.

The lecture was illustrated by numerous lantern slides showing the pathological changes in various organs resulting from the action of alcohol.

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#### ON EPILEPSY.

[*Abstract.*]

SIR WM. H. BROADBENT, BART., K.C.V.O.

AFTER a description in detail of the phenomena of epilepsy, Sir Wm. Broadbent proceeded to discuss (1) the etiology, (2) the prognosis, and (3) the treatment of the disease. A summary of his remarks is presented in the following paragraphs:—

ETIOLOGY.—The most important element in the causation of epilepsy is an inherent tendency in the nervous system. This tendency is for the most part inherited, and it is frequently found in family association with other neuroses. In some individuals the predisposition exists in so full a measure that the epileptic attacks begin to display themselves early in life, and continue in spite of circumstances most favourable to the patient. In other instances the epileptic tendency may long remain latent, and only translate itself into activity under the influence of conditions which injuriously affect the tone of the nervous system, such, for example

as alcoholism, excessive smoking, or sexual abuse. Puberty, or during adolescence, are the periods in which, in most cases, epileptic fits first commence. It is comparatively rare to observe their establishment in infancy or childhood. Sometimes, it is true, they appear to follow attacks of infantile convulsions, but such convulsions, appearing as they do indifferently in the epileptic and the non-epileptic, are in themselves no proof of a neurotic inheritance, and in cases where epilepsy follows them there is probably structural damage to the brain. On the other hand, when the first manifestations of epilepsy occur in adult life the influence of some definite exciting cause is to be suspected; or it may be that the convulsive seizures here are not true epilepsy but epileptiform attacks depending on such morbid conditions as syphilis in the young adult, cardio-vascular derangements or degenerations after middle life. It is probable that sensory or afferent nervous impressions originating in peripheral irritation play a not unimportant part in the causation of epilepsy in individual instances. Certain it is that peripheral irritation may cause convulsive seizures, even in individuals entirely free from epileptic taint. Such a statement receives confirmation from the occurrence of infantile convulsions excited reflexly by painful dentition, and from parallel experiences in adults. Sir Wm. Broadbent has seen epileptiform attacks cease after removal of a necrosed terminal phalanx, and also on extraction of a piece of glass embedded under the skin in close relation to the median nerve at the wrist. It is thus an important clinical rule, that when at any period of life there is a sudden and frequent eruption of convulsive seizures some definite peripheral excitement should be suspected. What is true of the non-epileptic in this respect is probably still more appropriate to those of epileptic inheritance. And as in a state of health, it is on the receipt by the nervous centres of afferent impressions from the great viscera that a sense of well-being depends, it is reasonable to believe that derangements of these organs by producing peripheral irritation may be in some cases the exciting cause of true epilepsy. The complete solution of the problem of epilepsy is, however, far from being provided by the statement that peripheral irritation may determine the occurrence of convulsions. Even the exact changes in the central nervous

system which precede and produce convulsions are not fully known to us, and their complete apprehension would still leave the consideration that convulsions are not the first, and possibly not the most important element in an epileptic attack. There is no doubt that so far as the nervous system is concerned a convulsion means an excessive and disorderly liberation of nerve energy. Assuming that the normal function of the cells in the cerebral cortex is to accumulate a substance of an explosive character, which in particular circumstances may undergo instantaneous transformation and so lead to the orderly and limited nervous discharges on which purposive muscular action depends, it may be conjectured that in epilepsy the explosive material manufactured in the cortex or other important nerve centres is less stable than normal, and thus on slight provocation, or even spontaneously, translates its potential into kinetic energy. It is not easy to define the factor on which this abnormal nervous metabolism depends. Malnutrition may have something to do with it, but in exceptional instances epilepsy is associated with a high level of mental capacity, as if the perversion were in the direction, not of inferior quality, but of undue sensibility of nerve substance. The conditions which produce the abnormal nervous explosion are equally difficult of explanation. Convulsions occur in such very different clinical circumstances that it is not easy to isolate the essential factor. Various experimental methods which induce convulsions have in common one circumstance, namely, more or less sudden arrest of the cerebral circulation. This fact certainly claims consideration in discussing the cause of epileptic and other convulsive seizures. It may be associated with two suggestions arising from clinical experience. The one, by Dr. Hughlings Jackson, that the immediate cause of a convulsion is spasm of the arterioles of the cerebral cortex, the other, by Sir Wm. Broadbent, that the convulsions of uræmia depend, not on the action of any poison on the nerve centres, but on stoppage of the circulation in the cortical capillaries. There is in the clinical phenomena of epilepsy one feature which it may be suggested appears to indicate a possible relationship between the occurrence of the convulsive attacks and the state of the cerebral circulation. This is the fact that the fits are very liable to occur during the night, or in the early morning, or soon after rising.

Now it is beyond question that during sleep the circulation seems to run down, and the vascular pressure to fall. The fits, that is to say, display a tendency to develop at the very time when the tone of the cardio-vascular system is at its lowest level. And, further, it is possible that the act of rising into the erect posture is capable of producing a disturbance of the cerebral circulation analogous to the disturbance of the renal circulation which gives rise in some patients to cyclic albuminuria. Thus certain of the facts of epilepsy, together with the recognised relationship between the state of the cerebral circulation and the appearance of convulsions, appear to warrant the hypothesis that the condition of the vascular supply of the brain may be an influence in exciting the occurrence of the convulsive attacks.

**PROGNOSIS.**—The prognosis in a case of epilepsy is largely influenced by the existence or otherwise of an inherent tendency to the disease. A family history of epilepsy, insanity, alcoholism, or even of hysteria, or migraine; personal evidences of a low type of nervous organisation or of faulty shape or size of the cranium; and fits commencing in childhood or early puberty, with regular and frequent recurrences, establish the existence of an inherent tendency and afford little or no hope of cessation of the attacks. On the contrary, the presence of general bodily and mental vigour, an onset late in the period of adolescence or postponed until the attainment of adult life, and the existence of some definite exciting cause, justify the presumption that there is no strong inherent tendency to the disease, and that it may possibly be held in abeyance. Another factor in deciding the prognosis is the state of the pulse tension. When, as is usually the case in epileptics, this is unduly low, it is a fact of unfavourable import. On the other hand, a pulse tension abnormally high for the age of the patient is an encouraging sign, and gives reasonable hope of complete recovery.

**TREATMENT.**—An open-air life, interesting employment, and plenty of exercise, are conditions necessary for all epileptics. In reference to the last mentioned it should be remembered that attacks rarely come on during exertion. Riding may therefore certainly be permitted, also swimming if under competent supervision; cycling is perhaps more hazardous, though Sir Wm. Broadbent has never heard of an accident. The risk with respect to active out-door

games is not of an attack at the time, but afterwards, more especially on the following morning. The question of school, at least in the case of boys, may generally be answered in the affirmative; the effects on other children, and the advertisement of the child as an epileptic, are the disadvantages. The diet should be carefully regulated so as to avoid digestive disturbances and constipation, and with a view to maintain the highest possible level of general health. Stimulants are to be avoided. In every case, however hopeless, these general hygienic and dietetic rules hold good, and similarly it is imperative always to carefully search for and remove any influence which may act as an exciting cause. The medicinal treatment too often resolves itself into the administration of bromides. There can be no doubt that these have a marked influence in reducing the frequency of the fits. But their administration is not infrequently practised as a mere matter of routine, and without an intelligent study of the particular claims of the individual patient. It may be questioned, too, whether the lessened frequency and violence of the epileptic attacks is not sometimes purchased at too great a price, paid in the shape of a lowered tone of the nervous system, mental and physical depression, and impaired enjoyment of life. The underlying condition in epilepsy is less a liability to the outburst of nerve energy in consequence of deficient resistance, than the formation of an unduly explosive nervous substance, the result of malnutrition. The chief end of treatment is not therefore to dull the sensitiveness of the nerve centres, but to increase their vigour and stability. Occasionally, when the attacks depend on visceral, especially perhaps ovarian irritation, the bromides, by lessening the sensitiveness of the nerve centres to external impressions, may secure for the centres the opportunity to regain their equilibrium, and may thus effectively cure the disease. The same thing may be true when the epilepsy is the result less of an inherited tendency than of some of the varied influences which lower nerve tone, and the centres need some protection and quiet in order to acquire the re-establishment of their normal stability. But for the most part, whilst a judicious use of the bromides may accomplish some control of the symptoms, it is from measures which improve the nutrition and tone of the nervous system that a cure of the disease must be anticipated. An

outline of general rules for treatment may be presented as follows :—

When the fits occur at intervals of six weeks or longer the bromides should not be given continuously, but only in short courses before the anticipated attacks, unless mental excitement or sleeplessness calls for more persistent administration. Similarly, when the patient is aware of symptoms which he knows from experience herald the onset of an attack, he should be instructed to take bromides immediately. The same is true when worry, excitement, exertion, etc., determine a fit, the bromides being ordered with a view to check this. With frequent fits which bromides are proved to control, these must be ordered in such amounts as are found necessary, adjusting the doses according to the time incidence of the attacks. Mere diminution of the seizures, however, is not to satisfy the physician. Every opportunity must be utilised to trace out and remove exciting causes, and to restore by all possible measures the stability of the nervous equilibrium. The patient's habits of life must be carefully ordered and disciplined in every respect, and there must be provided for him an atmosphere in which mental support and moral control reinforce his own defective inhibitory power. The general physical condition must receive careful attention, and all functional bodily derangements such as indigestion, constipation, menstrual disturbances, etc., must be judiciously rectified.

In those cases in which the fits occur during the night or soon after rising, some attention might well be paid to the state of the circulation, and measures which tend to keep up arterial tone adopted. A glass of hot milk or a cup of beef tea, at bed time in the one case, or on waking in the morning in the other, would be in the right direction. In the latter instance some more definite stimulant might be added, as aromatic spirit of ammonia to the milk, or a little cayenne pepper to the beef tea. A dose of digitalis at night or of nitro-glycerine in the morning might also be ordered, though on the whole it is desirable to avoid drugs. For the generally lowered vitality of epileptics, tonics such as phosphorus, the hypophosphites, arsenic, strychnine, and in some instances iron, are available. If not curative, they at least often produce remarkable improvement ; the fits diminish both in frequency and severity, and the patient's general well-being and happiness are promoted.

## EYEBALL TENSION FROM A CLINICAL POINT OF VIEW.

[*Abstract.*]

F. RICHARDSON CROSS, F.R.C.S.

THE globe of the eye, consisting of a strong fibrous capsule enclosing the various refractive media, together with nervous structures, blood-vessels, and lymphatics, exists in a state of considerable tension. The degree of tension can be estimated for clinical ends by the amount of force necessary to "indent" the globe, using for this purpose two fingers applied through the upper lid in some such fashion as in appreciating fluctuation in an abscess or cyst. By practice the observer comes to recognise the limits of normal tension. The standard is not an absolute one. The exact amount of tension varies both in different eyes, and at different times in the same eye. But experience gradually gives to the judgment a confident capacity to say whether in a given case the tension is within or without the normal range.

A factor of great moment in the production of ocular tension is the condition of the blood—vascular and lymphatic circulations. These, of course, govern the entrance and exit of fluid to and from the globe; and so long as equilibrium between these two currents is maintained, the ocular tension will be normal. But in conditions which drive more blood into the eye, or interfere with the venous return, the tension will rise. Such an increase of tension usually soon rights itself, but it is readily conceivable that a persistent or frequently-repeated state of venous stasis might cause permanent high tension, together with the serious structural changes which result from permanent high tension. Similarly, the flow of fluid in the lymphatic channels must exercise an important influence in the determination of ocular tension. All these are factors in determining the amount of fluid in the eyeball, and play a part in the production of ocular tension. But of still more importance in this association is the activity or otherwise of the glands in the ciliary body. Normally, the fluid secreted by the

glands of the ciliary body circulates through the vitreous, and, for the most part, passes into the space (posterior chamber) immediately behind the iris, and thence forwards through the aperture of the pupil into the anterior chamber. From this it is drained off at the corneo-iritic angle (often called the filtration angle) through the trabecular spaces of Fontana into the canal of Schlemm, from which it enters the outgoing lymphatics of the eyeball. Should the secreting glands of the ciliary body atrophy, or from some other cause become less active, it is obvious that the fluid contents of the eyeball would be diminished, and the ocular tension would consequently fall. On the other hand, should some block in the drainage apparatus occur, say, for example, at the filtration angle, fluid would tend to accumulate in the eyeball, and the tension would therefore be raised. The above considerations show (1) in what manner variations in the ocular tension may be produced, and (2) that in some circumstances an increase of tension, even considerable in degree, may be caused for a limited period by temporary disturbances of the vascular and secretory apparatus of the eyeball. Such a transitory increase of tension is quite possible without leading to organic changes in the eye, and this conclusion is not only in harmony with clinical experience but can be demonstrated by actual experiment. At the same time, it may well be the case that circumstances which produce a temporary increase of tension, if continued or frequently repeated, may in time prove the starting point of a definitely pathological process. It may be taken as certain, that any eye with persistent increase of tension is in a condition of peril, and may need for its relief operative interference.

*Pathological increase of tension* constitutes the condition known as *glaucoma*. In this disease there is produced, in some way or other, a blocking of the corneo-iritic or filtration angle. The lymphatic exit from the eye is thus rendered imperfect, the fluid contents of the globe are increased, and the tension is raised. As a consequence of this pathological tension, serious structural changes occur. These include shallowness of the anterior chamber, haziness going on to opacity of the media from alterations in the fluids of the eye, and optic nerve failure, with resulting diminution of visual acuity, contraction of the visual field commencing on the nasal side, and in time, complete blindness.

When a previously diseased state of the eye is the cause of the increased ocular tension, and glaucoma results, this is spoken of as *secondary glaucoma*; when there is no antecedent disease to explain the increased tension, the condition is termed *primary glaucoma*.

*Secondary glaucoma* may develop in various circumstances. The one essential condition is a block at the filtration angle. The following are illustrations:—

(a) Iritis with adhesions or exudation situated so as to prevent fluid passing through the aperture of the pupil into the anterior chamber. In these circumstances fluid will accumulate behind the iris, the periphery of which, being driven forwards, is jammed against the circumference of the cornea so as to occlude the corneo-iritic angle.

(b) Injury to the lens. The capsule being torn, fluid from the aqueous enters, and causes swelling of the lens fibres. The lens thus enlarged presses outwards against the ciliary body and iris, and in this way a block at the filtration angle is produced. The penetration of the capsule, with subsequent swelling of the lens, is exactly what occurs in the operation of needling. The greater elasticity and yielding quality of the fibrous capsule of the eye in early life, explains why this operation can be safely performed in a child, whilst in an adult it entails the risk of secondary glaucoma. This yielding capacity of the young eye is well illustrated in the condition known as *buphthalmos*, in which the globe is greatly enlarged so as to resemble the large eye of the ox. The cornea is increased in diameter, the sclerotic is thinned, and the whole eye is, as it were, distended into a large globe. The anterior chamber is not shallow, but deep. Thus at first sight it would appear that the filtration angle instead of being narrowed or blocked is unduly large. The explanation is that the angle was originally blocked, probably during intra-uterine life, and its increase is a later change, occurring with the distension of the entire globe. The tension in such an eye is increased, and the condition is sometimes called *congenital glaucoma*. It is better, however, to confine the term glaucoma to conditions in which, with increased tension, there are such symptoms as haziness of vision, the appearance of coloured halos round lights, atrophy and cupping of the optic disc, and pulsation of the retinal arteries, without any special enlargement of the globe. Mere increase of

tension is not glaucoma. The latter term is a clinical one, applicable to such a symptom-complex as has just been described. It was Mackenzie, of Glasgow, who first noted the association of the "hard eye" with the greenish, glassy appearance of the pupil which develops in the late stages from change in the media, and from which the name of the disease takes origin. The necessity for distinguishing between *buphthalmos* and *glaucoma* is all the more necessary as glaucoma in its ordinary form does sometimes occur in childhood.

(c) A dislocation of the lens upwards and forwards into the anterior chamber may block the filtration angle and cause secondary glaucoma.

(d) Similarly, after cataract extraction, or after needling an opaque capsule, blocking of the filtration angle may occur in consequence of some fibres of the capsule lodging in the corneo-scleral wound and leading to the formation of adhesions in the corneo-iritic region.

(e) *Retinitis* and *choroiditis* may each sometimes be followed by secondary glaucoma. Here the probable explanation is that the fluids of the eye, in consequence of secretory and vascular disturbances, become so changed in quality that they cannot readily pass away through the drainage channels. There is no mechanical block in the channels themselves, but an alteration in the quality of the fluid to be removed. Upon this depends a point in treatment. When the cause of the high tension is an interference with the size of the filtration angle it can usually be overcome by a free iridectomy, which, by tearing away a portion of the periphery of the iris, permits free drainage to again proceed, and this is the usual treatment in most cases of secondary glaucoma. But such a serious operation is not required to relieve increased tension due to imperfect outflow depending on an alteration in the quality of the fluids. Here the only necessity is to tap the eyeball and to allow some of the fluid to escape.

*Primary glaucoma* develops without the pre-existence of any lesion which would account for the increased tension. It is almost entirely a disease of advanced life, and a probable factor in its evolution is a disproportion between the size of the lens and the size of the eyeball. As age advances there is no increase in

the size of the globe, and the fibrous capsule becomes gradually more tough and resistant. The lens, on the other hand, grows both larger and flatter. It therefore intrudes more or less on the peri-lenticular space (canal of Petit), and may block this space. In these circumstances the lymphatic circulation of the eyeball will be disturbed, and should the peripheral extension of the lens lead to pressure on the ciliary body, the iris at its circumference will be driven forwards against the cornea, and thus there will be blocking at the filtration angle. Congenital smallness of the eye will predispose to the establishment of these conditions, and hence it is that glaucoma is a disease largely confined to hypermetropic eyes. In some instances the lens may be from birth abnormally large, and the peri-lenticular space relatively small. And when, with these circumstances, the eyeball as a whole is small, it is easy to see how glaucoma may develop, sometimes even at a comparatively early age.

The *pathology of glaucoma* affords an explanation of the successful treatment of the disease by iridectomy or by myotics (eserine, pilocarpine, etc.). Iridectomy, as already explained, removes the mechanical obstruction at the filtration angle. Remedies which contract the pupil have a similar effect, as they draw the mass of the iris towards the centre, and thus relieve pressure at the periphery. On the contrary, mydriatics (atropine, cocaine, etc.) will increase the risks of glaucoma, as they lead to crowding of the bulk of the iris at the periphery, and so increase the obstruction on which the increased tension depends.

Pathological increase of the ocular tension is sometimes met with in *iritis* and *cyclitis*, and it is of the first importance to distinguish between glaucoma with inflammation, and irido-cyclitis accompanied by increase of tension. The explanation of the latter is that leucocytes and other solid elements in the exudation block the lymphatic channels which drain the eye. Here an iridectomy is unnecessary, and often useless. Nor will myotics relieve the tension. Further, eserine or any other substance which contracts the pupil is dangerous, for by keeping the pupil small, adhesions of the iris to the lens are made more probable, and there is a risk of occlusion of the pupil. The treatment which is so dangerous in glaucoma is here absolutely essential, namely, the use of atropine, to keep the

pupil dilated, whilst, if necessary, the tension must be reduced by tapping the globe.

*Diminished intraocular tension* is a less important clinical condition than increased tension. It occurs when, in consequence of a wound or perforating ulcer of the cornea, the aqueous is allowed to escape. It is also found in some conditions where there is no leakage from the globe. Thus the tension is diminished in detachment of the retina, possibly from some change in the secretory activity of the ciliary body. The same thing may be noted at times in sympathetic ophthalmia, and occasionally in cases of tumour, though in the great majority of the latter there is definite increase of tension.

The lecture was illustrated by diagrams and by numerous sections showing various pathological conditions of the eyeball.

## NOTES OF CASES DEMONSTRATED IN THE CONSULTATION THEATRES.

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### MEDICAL CASES.

BY JAMES TAYLOR, M.D., F.R.C.P.

*Tuesday, November 5, 1901.*

#### *Cases of Disseminated Sclerosis.*

A SERIES of cases of disseminated sclerosis formed an impressive clinical picture of the different modes in which this disease commences, and of the various expressions which it presents in different individuals. As the situation of the sclerosed patches in the central nervous system offers no constant pattern, it follows that there is a wide range of possibility in the symptomatic results, and that a clinical sign of the disease which is marked in one patient may be entirely absent from others. These facts make it specially important to observe a large collection of patients. Hence the great value of a clinical series which rendered possible an opportunity for contrast and comparison. What are usually described as the typical symptoms of disseminated sclerosis are weakness, with more or less spasticity, of the lower limbs, tremor appearing on voluntary movement—the so-called intention tremor—exaggeration of the tendon jerks, nystagmus, scanning or syllabic speech, and often a degree of optic atrophy. In the cases summarised below it will be observed that these symptoms are variously combined in different patients; that in individual instances one or more are completely suppressed; and that there are other symptoms, associated more especially with the onset of disseminated sclerosis, which are highly suggestive of the diagnosis, and frequently form a part of the clinical manifestations of the disease.

(1) A youth of 19 years in whom for some months there had been a sense of numbness and stiffness in one lower limb. In his present condition, the gait, except for some degree of stiffness, scarcely departed from the normal, though in this respect he had improved under rest, good food, massage, galvanism, and tonics. The only other definite objective evidence of the disease was exaggeration of the knee-jerks. There was no ankle clonus, no intention tremor, no nystagmus. The history of the patient revealed a fact of great interest and moment. Four years before the onset of his present illness, without obvious cause and somewhat suddenly, he lost the sight of his right eye. Ophthalmoscopic examination revealed little change in the fundus beyond perhaps slight pallor of the disc, and a diagnosis was made of retrobulbar neuritis. After a time, as is frequently the case in retrobulbar neuritis, sight was regained. But it is known that a certain proportion of patients who suffer from this affection, and who, as far as vision is concerned, make a good recovery, subsequently display undoubted evidences of disseminated sclerosis. The present patient is an instance of this sequence, and it is worthy of note that so long an interval as four years intervened between the occurrence of the retrobulbar neuritis and the recognised symptoms of disseminated sclerosis.

The improvement in this patient is another fact to which attention should be directed. It has been obtained by simple and common-sense measures, and so far as improvement is possible in these patients it is to be produced by similar treatment to that here adopted. Unfortunately it is hardly possible to expect its continuance. One of the frequent features in the clinical history of disseminated sclerosis is the diminished prominence or even entire disappearance of particular symptoms, with a subsequent development of the disease in other directions. The former feature of the disease is apt to encourage delusive hopes, and sometimes leads to serious errors in diagnosis and prognosis. Especially is this the case when, as occasionally happens, an early event in the development of the disease is a temporary paralysis of one or more limbs. The disappearance of the paralysis, unless great care is taken, readily leads to the conclusion that the case is a functional or hysterical one, and to a relatively cheerful prognosis. Many examples of

disseminated sclerosis in the early stage in young women are mistaken for hysteria. In occasional cases it may be difficult, at least at the outset, to be certain, but it should be remembered that sustained ankle clonus, extensor response of the great toe to plantar stimulation, nystagmus, paralysis of ocular muscles, and optic atrophy, are all evidences of organic disease and negative a diagnosis of pure hysteria. The last statement is necessary because it is not infrequent to find that with evidences of organic nervous disease undoubted hysterical manifestations are associated. The latter may be, and often are conspicuous, whilst the former are perhaps slight and only to be detected on careful examination. Unless, therefore, they are searched for they may be overlooked, and the true nature of the case entirely misinterpreted.

(2) A man of 21 years. The first symptom which attracted this patient's attention was diplopia. It is one of the commonest of the early signs of disseminated sclerosis. The double vision was soon succeeded by trembling of the lower limbs when walking. Now the gait shows the usual association of spasticity with incoordination; there is a degree of swaying when Romberg's test is applied; the knee-jerks are exaggerated; and extreme ankle clonus is readily elicited. The ocular symptoms included not only nystagmus, but also inequality of the pupils and weakness of the right external rectus muscle. The history showed that the patient had suffered a somewhat severe injury to his back some three years ago, and that since this he had never felt well. In this respect the case is one of many in which mechanical injury would appear to determine the development of organic nervous disease. Whether it is in itself an effectual cause of such disease, or whether it merely localises the expression of some vice inherent in the nervous tissues, is a question difficult to solve. But of the fact that the manifestations of chronic nervous diseases not infrequently appear after injuries there can be no doubt.

(3) This patient was a man aged 55 years. The age of the patient at once presents an exception to the usual rule that disseminated sclerosis is a disease of early adult life. But such exceptions occur, and this is one of them. Another noteworthy fact is the earliest development of tremor in the upper limbs. The patient had been a carpenter, and the first experience that suggested

to his mind that all was not well, was trembling of his hands when using his tools. Now, tremor in the upper limbs is very marked, and further, the tremor very definitely affects the head, which is not common in disseminated sclerosis. On the other hand, the lower limbs are comparatively little affected, and there is no nystagmus even when the eyes are fixed in extreme lateral deviation. The patient admitted some little difficulty in the action of his bladder, but evidently did not consider it of much importance.

(4) In this case the diagnosis was a somewhat less confident one. The patient, a woman of about 25 years, had some difficulty of walking due to spastic rigidity of the lower limbs, and there was great exaggeration of the knee-jerks and marked ankle clonus, these facts proving the existence of sclerosis of the lateral columns of the spinal cord. The spinal column was normal to examination, so that pressure on the cord from caries of the vertebrae could be excluded. It is important to make this examination in all cases where the function of the lower limbs is impaired, otherwise a patient who ought to be lying in bed may be allowed for some time to walk about, to his own great injury. In the present patient the facts as at present existing merely claimed a pathological diagnosis of lateral sclerosis. There was no intention tremor in the upper limbs, no nystagmus, and no disturbance of the bladder. Yet in all probability the case essentially is one of disseminated sclerosis in which the areas of sclerosis, so far, affect only the motor strands associated with the lower limbs. The patient had attended the Polyclinic in the earlier part of the year, and Dr. Taylor had then advised the administration of simple tonics, and the application of Pacquelin's cautery on each side of the lower dorsal and lumbar spines. In some cases of chronic disease of the spinal cord the cautery appears to act very beneficially, though in others it has not the slightest effect.

Regarding the series of cases above discussed two remarks may be added to those in the preliminary paragraphs. First, it will be observed that in no single instance is any note made of any appreciable defect of speech. The reason is that no such defect existed in any of the patients. And this illustrates what is true in the great majority of the patients suffering from disseminated sclerosis.

When the speech is slurred or syllabic it is no doubt a valuable sign, but in most cases this symptom is not present to help the diagnosis. The second remark is that in only one of the patients was there any admitted bladder difficulty. Yet some defect in the bladder function is a frequent event in disseminated sclerosis. Sometimes it takes the form of incontinence, sometimes of difficulty in starting the act of micturition. Indeed, the bladder disability may be, and not infrequently is, the first evidence of the disease, and like many other symptoms it may entirely and completely disappear. Yet, as the present instances show, quite a number of cases occur in which the functions of the bladder are discharged without the slightest irregularity.

#### *A Case of Pseudo-hypertrophic Paralysis.*

This case illustrated the very slow advance which marks, in particular instances, the course of pseudo-hypertrophic paralysis. The patient was a girl of 14 years who complained of some not very clearly defined disability in walking. According to her mother's statement she had been a slow walker all her life, and this slowness of gait, and some difficulty in mounting stairs, were the only two symptoms which the patient would allow. Nor could observation of the patient's movements in the act of walking find much ground for criticism other than the remark that the gait was sluggish in character. Examination, however, revealed absence of the knee-jerks. Beyond this, objective evidence was scanty. The calf-muscles were rather bulky, more especially considering the fact that the limbs were somewhat wanting in power. Further, attempts to depress the upper limb against resistance caused a tilting outwards and backwards of the vertebral border of the scapula, as though the serratus magnus was in some measure weakened. On these facts a diagnosis of pseudo-hypertrophic paralysis was made. The absence of the knee-jerks must be accepted as a definitely abnormal fact. It may be due in children to infantile paralysis (provided the quadriceps extensor is involved), Friedreich's hereditary ataxia, post-diphtheritic paralysis, or muscular dystrophies affecting the thigh muscles. In the present case there was no evidence in favour of any one of these conditions except the last-

mentioned. The absent knee-jerks and the long-continued muscular weakness support the theory of muscular dystrophy, and the enlargement of the calf-muscles justifies the term pseudo-hypertrophic. It is probable that the case is one in which the disease commenced in early life and has made but little advance. Occasionally this does happen, though in most cases the muscular atrophy and weakness make relatively rapid progress. The rate of change in different cases of muscular dystrophy (myopathy), however, varies considerably, and there are instances on record in which the disease has presented but little advance over even a long term of years. In reference to the treatment of pseudo-hypertrophic paralysis many remedies, including thyroid and thymus gland, have been tried, but entirely without success. The indications are (1) to maintain and promote the patient's general health, and (2) to encourage the nutrition of the affected muscles by walking and other exercises, not pushed, however, to the point of fatigue.

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## SURGICAL CASES.

BY JAMES BERRY, B.S., F.R.C.S.

*Wednesday, November 6, 1901.*

### *Malignant Disease of the Oesophagus.*

THE patient, a man of 53 years, complained of difficulty of swallowing and decided loss of weight, of four months' duration. The fact of oesophageal obstruction was placed beyond doubt by the abrupt stoppage of a bougie at a point thirteen inches from the incisor teeth. Thus there only remained the question of the nature of the obstruction. Pressure of an aneurism or other mediastinal tumour was excluded by careful examination of the thorax; there was neither history nor evidence of syphilis; and the patient had never swallowed any corrosive substance capable of injuring the oesophagus. These negative considerations inevitably suggested the diagnosis of malignant disease—a diagnosis which the age of the

patient, the history of the case, and the site of the obstruction, decidedly favoured. Confirmation was also obtained in the shape of a firm glandular enlargement deeply seated behind the sternal end of the left clavicle. It is important always to carefully examine the root of the neck in cases of suspected malignant disease of the oesophagus. Glandular enlargement may often be detected there, even when the original tumour is near the lower end of the gullet. Occasionally the enlargement is considerable, and may attract the patient's attention before he is aware of any appreciable degree of dysphagia. Hence the important clinical memorandum—that the presence of enlarged lymphatic glands at the root of the neck numbers among its possible explanations the existence of malignant disease of the oesophagus.

*Malignant Ulcer of the Pharynx ; Secondary Tumour in the Neck.*

The importance of remembering that a tumour in the neck, of more or less doubtful nature, may be a secondary expression of malignant disease in some portion of the upper part of the alimentary canal, was emphasised by the case of an elderly man who had no symptoms other than a swelling on the left side of his neck, pain passing down the left arm, and slight dysphagia. Yet inspection of the pharynx revealed the presence of a large epitheliomatous ulcer, and showed how a serious mistake in diagnosis might have been made had this examination been neglected. The tumour in the neck, which was hard, nodular, and the size of a hen's egg, presented certain anatomical relations of diagnostic moment. It was situated behind, and was firmly adherent to, the middle of the sterno-mastoid muscle. The carotid artery passed in front of it, suggesting very strongly that the growth took origin from the pharynx or oesophagus, as compared with tumours arising from the thyroid or from lymphatic glands of the anterior triangle, which are either placed in front of the carotid or displace the artery outwards. The larynx and trachea were pushed to the right, but in the act of swallowing moved without altering the position of the tumour, thus providing a further distinction from tumours of the thyroid. The pain in the arm indicated involvement of the brachial plexus, and a

relatively weak pulse in the upper part of the carotid and in the left temporal artery showed that the carotid wall was also infiltrated by the growth. With all this it had to be noted that there was neither dyspnoea, dysphonia, nor any evidence of affection of the recurrent laryngeal or sympathetic nerves, and that difficulty in swallowing was only slight in degree. The treatment, Mr. Berry explained, could only be palliative. If dyspnoea became urgent tracheotomy might be required, and dysphagia might demand feeding through a tube and possibly even gastrostomy.

*Case of Goitre and Acromegaly.*

The patient was a woman aged 37 years. She complained of severe attacks of shortness of breath, more especially at night. Examination detected a goitre which to the extent of about one-half of its mass passed behind the sternum. Mr. Berry pointed out how very apt goitres having this character are to produce dyspnoea, and explained that when they are entirely or mainly substernal they may readily be overlooked. In the present case the limitation of the tumour to one lobe, its smooth surface, and its mobility, proved the tumour to be encapsulated and therefore capable of being enucleated; and the urgency of the dyspnoea, and especially its nocturnal character, made operation advisable. This patient was also the subject of acromegaly.

[The tumour was enucleated a few days later and proved to be an adenoma containing numerous very small cysts. It was about the size of a hen's egg.]

*Abscess of the Abdominal Wall in Communication with the Gall-Bladder.*

The patient, a man of 71 years, had in the upper right abdomen a rounded, slightly prominent, smooth mass, having a diameter of six or seven inches, and very obvious both to sight and touch. When the abdominal muscles were thrown into action, as by the endeavour to rise from a lying to a sitting posture (the arms being folded), the tumour did not disappear, which indicated that it involved the abdominal wall. Further, the swelling did not move with respiration, and it could be displaced backwards but not in any

other direction. From these facts it was concluded that either the tumour was limited to the abdominal wall, or that it originated in some viscus in the anterior part of the abdomen and had become adherent to the abdominal wall. The tumour was dull to percussion, and the dulness was continuous above with the hepatic dulness, but both to the right and left of the mass there was no evidence of enlargement of the liver. Hence its origin from the liver seemed improbable.

The patient gave a history of good health until five weeks ago. He was then suddenly seized with vomiting and severe pain in the right hypochondrium. In the course of a few days, the acute symptoms having subsided, the swelling appeared, and though painful for a time, it soon gave the patient little or no trouble. This history suggested an inflammatory affection, possibly a small perforation of some viscus, or a limited peritonitis around a new growth. A tumour of the pylorus or transverse colon was considered possible, though very unlikely in view of the good health and satisfactory nutrition of the patient, and of the absence of all symptoms pointing to either of such growths. Another possibility discussed was suppuration round an enlarged gall-bladder, and cases were quoted in which gall-stones had led to adhesion of the gall-bladder to, and to suppuration involving, the abdominal wall. It was pointed out that a normal temperature and the absence of marked tenderness over the tumour did not exclude the existence of pus, and that the consistence of the tumour suggested the presence of fluid. Beyond the conclusion that the tumour was inflammatory in nature and probably contained pus, that it involved both the interior and wall of the abdomen, and that it originated in disease of some viscus in the neighbourhood of the under surface of the liver, with a balance of probability in favour of suppuration in connection with the gall-bladder, the diagnosis could not be advanced. [A subsequent exploratory incision resulted in the evacuation of several ounces of pus and numerous small gall-stones. The pus was mainly in the deeper parts of the abdominal wall.]

The other cases demonstrated were—(1) A patient with recurrent lymphadenoma of the glands of the neck; (2) A woman with stricture of the rectum; and (3) A case of extreme talipes varus suitable for astragalectomy.

## DISEASES OF THE EYE.

BY E. TREACHER COLLINS, F.R.C.S.

*Friday, November 8, 1901.**Nævus of the Eyelid.*

An infant aged 1 year and 10 months, born with a nævus involving the skin and subcutaneous tissue of the whole of the left lower lid. During the first few months of life the nævus steadily increased in size. It was obviously impossible to either excise, tie, or destroy it with caustics, without giving rise to ectropion from cicatrisation. Treatment by electrolysis was therefore employed. The positive pole, with a flat terminal, was applied to the temple, and sometimes one, sometimes two needles, connected with the other pole, were inserted in several different places into the growth. Fourteen sittings had been required to completely destroy it. The final result, as shown, was most satisfactory. All that now remained in the region of the growth was some irregularity and puckering of the skin. There was not the least displacement of the margin of the lid.

*Congenital Trichiasis.*

The patient was an infant a few months old presenting a very unusual form of congenital abnormality of the lower lids, viz., congenital trichiasis. Some of the eyelashes of each lower lid, instead of being directed outwards and downwards from the margin in the normal way, passed upwards and inwards towards the eye and rubbed against the surface of the cornea and ocular conjunctiva. They gave rise to a slight amount of irritation and lachrymation.

There was only one row of lashes, that is true trichiasis, not distichiasis. The edge of the lid did not seem to be bent, so it was not strictly speaking a case of entropion. There was an unusual thick and prominent fold of the skin in each lower lid. The condition has been figured and described by Mr. Sydney Stephenson

in the *Trans. Ophth. Soc.*, vol. xiv., 1894, p. 13. Two suggestions had been made as to its causation; one that there was an over-development of the orbicularis muscle, more especially of those fibres which keep the margin of the lid in close contact with the surface of the eye; the other, that there was an undue development of the tarsus. No anatomical examination of a case of this sort has so far been made.

The treatment, which it was proposed to adopt, was that which proved so satisfactory in the spasmoid entropion of the lower lid of elderly people, viz., the removal of a strip of skin parallel with the margin of the lid, and a piece of the orbicularis muscle.

#### *A Case of Episcleritis.*

A girl aged 16 with patches of episcleritis in each eye—two in the left and one in the right. The inflammation had commenced two months ago, and during the last ten days, while she had been under treatment, had somewhat diminished in intensity.

The way in which the affection can be distinguished from other inflammatory conditions involving the surface of the eye was pointed out. Its localised character and the absence of any discharge served to distinguish it from a general conjunctivitis. From a phlyctenular conjunctivitis it could be diagnosed by the absence of any little millet-seed-like efflorescence or ulcer on the surface of the reddened patch and by the injection involving the ciliary vessels in the superficial parts of the sclerotic, not only the conjunctival vessels.

It is exceptional to meet with this disease in a patient so young. It is elderly people who are mainly liable to it. The case was also exceptional in that no history of gout or rheumatism, either in the patient or her family, could be obtained. In fact there was no constitutional history which threw any light on the cause of the affection in this patient.

The strong tendency which there is for fresh patches of a similar character to form in a patient who has once had this affection was mentioned. Also that the new patches never appear in the same site as the old ones, but in a part which had not previously been involved. The old sites are always recognisable by a slaty discolouration of the sclerotic which remains as the inflammation subsides.

The treatment which had been prescribed was—locally, massage over the affected area, a little yellow oxide of mercury ointment having been first introduced into the eye; and internally, salicylate of sodium in ten grain doses.

*Lupus of the Face causing Ectropion.*

A man who for twelve years had been afflicted with lupus of the face which had produced extensive scarring and marked ectropion of each lower lid. For nine weeks his face had been treated every day by exposure to the X-rays at the London Hospital. All ulceration and scaliness having disappeared and the scar tissue having become less thickened and more supple, it was thought advisable to try some operative measure for the ectropion.

The scarring was so extensive that no flap of skin could be twisted or “glided” from some neighbouring part of the face. It was decided, therefore, to transplant a large and entirely detached piece of skin from the upper arm.

An incision was made a short distance from the displaced margin of the left lower lid and parallel to it. By dissection, it and the lower conjunctival sac were restored to their normal positions in relation to the eyeball. The margins of the eyelids were then stitched together with three horse-hair sutures. A paper pattern was cut of the raw surface which was left below the margin of the lower lid, and a piece of skin, slightly larger, was marked out and dissected off the inner side of the left upper arm. Care was taken to keep this flap as free as possible of any fat. It was next laid on the raw surface and maintained in position there by sutures passed across it, in the manner suggested by Dr. Argyll-Robertson. No suture was inserted in the flap itself. Iodoform powder was dusted over it and a dry pad of bi-cyanide gauze and wool applied. The dressing was not removed for a week, and the fresh dressing then applied was left for another week. By the end of that time the flap was found to have entirely taken, none of it having sloughed.

Eight weeks had now elapsed since the operation; the outline of the transplanted piece of skin could be seen; there was still a slight amount of ectropion at the outer angle, but infinitely less than on the right side, which formerly was the less affected of the two.

CASES OF SKIN DISEASE.<sup>1</sup>

BY H. RADCLIFFE CROCKER, M.D., F.R.C.P.

*Monday, November 4, 1901.**Tertiary Syphilis of the Face.*

The patient was a woman, aged 43. There was a great deal of scarring about the forehead, and gummatous infiltration over the left cheek. In the latter situation, the lesions, which had been improving under treatment, had recently broken down, with much ulceration, as a result of a five weeks' illness from some inflammatory internal complaint. During that time specific treatment had been suspended. She was again improving under local and general measures.

*Lichen Planus Linearis.*

A girl of 12 years. According to the mother the skin condition had been present three weeks. The eruption extended in a linear form from the middle of the left groin down to the commencement of the lower third of the thigh. There a break of about 6 inches in the continuity of the line occurred, but it started again at the inner border of the popliteal space and extended downwards and forwards to the lower border of the internal malleolus. The eruption was pale red in colour, and the line varied from one-eighth to half an inch in width. It was made up of papules which in many parts had coalesced into small irregular patches.

*Erythema Papulatum.*

The disease had lasted from twelve to fourteen years, the patient being a woman aged 50. She was never quite free, each attack lasting about a month. The eruption occupied the backs of the hands, where it was made up of flat papules which in parts had

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<sup>1</sup> Reported by Mr. G. Pernet.

coalesced; also the face, which was diffusely red and swollen, the papular character of the eruption being only made out at the borders. Patient had long been the subject of obstinate constipation, and this probably has some causal relationship to the erythema.

*Dermatitis Herpetiformis.*

The disease was of a mild type. The patient was 34 years of age and had been under observation for several years. From time to time he showed a symmetrical eruption of grouped vesicles on an erythematous base about the shoulders, axillary folds (back and front), buttocks and intergluteal fold. The regions of the knees and nape had also occasionally been affected. The disease had been troublesome since 1896. When shown (November 4, 1901), he exhibited the herpetiform rash about the axillæ, etc. This was a recent exacerbation, for he had lately been comparatively free.

Dr. Radcliffe Crocker then described the various vaccinal rashes, illustrating his remarks by coloured drawings. He also referred to horse-pox and accidental vaccination, showing drawings of cases that had come under his observation.

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DISEASES OF THE NOSE AND THROAT.

BY HERBERT TILLEY, M.D., F.R.C.S.

*Friday, November 15, 1901.*

*Case of Malignant Naso-Pharyngeal Tumour.*

THE patient was a boy of 14 years in whom a nasal polypus had been diagnosed, but who was found on examination to be the subject of a much more serious condition. There was considerable obstruction to the air-way in each nostril. On the right side the septum bulged into the right nasal cavity to such an extent as to come into contact with its outer wall. At the left nostril there presented a soft, fleshy mass with a grayish slough on the surface and bleeding very freely when touched with a probe. The boy had been aware of some nasal obstruction and discharge for about

eight months. The characters of the tumour and its rapid growth were sufficient in themselves to show that it was neither a simple nasal polypus nor a fibroma. Further, with the finger introduced through the mouth, the tumour was felt to take origin from the left lateral wall of the naso-pharynx where it appeared to have a broad base of attachment. With the transillumination test the left antrum was not translucent, but dark, showing that the growth had probably invaded the antral cavity. Such a combination of facts compelled a diagnosis of malignant disease, and the age of the patient, the absence of sub-maxillary glandular enlargement, the soft fleshy character of the tumour, the ease with which free bleeding was provoked, and the brief history, pointed with a high degree of probability to a diagnosis of sarcoma. The prognosis was therefore a most serious one. No surgical measure short of removal of the upper jaw can possibly be of any avail. A partial operation would mean not only free and possibly dangerous haemorrhage but rapid extension of the disease through the entire nasal fossæ. Even the proposal to remove the jaw is not very encouraging. Apart from risks incidental to the operation itself, there is the probability, practically the certainty, that the growth will recur at an early date. It thus becomes a question whether it is justifiable to advise the operation. Dr. Tilley expressed himself unable to accept the responsibility of recommending surgical treatment until he had had the opportunity of more carefully examining the boy, who is to be brought into hospital for this purpose. [The case has since been operated upon by Ollier's method. The growth was a sarcoma springing from the basisphenoid and neighbouring ethmoidal region. The haemorrhage during removal of the growth was very free.]

#### *A Case of Laryngeal Tuberculosis.*

The patient was a man of 50 years, who complained of hoarseness which had existed since last July. Such a symptom, more especially in a patient who has reached middle life, always demands a careful laryngoscopic examination. It may mean tubercle, malignant disease, syphilis, or some form of laryngeal paralysis. In the present patient there was no doubt about the diagnosis, for there were swelling and ulceration of the epiglottis, ventricular bands,

vocal cords, and interarytenoid commissure, and in addition physical evidences of excavation at the apex of each lung. There were two other features of clinical interest illustrated by this patient. First the mucous membrane of the palate had the peculiar waxy pallor so often seen in laryngeal tuberculosis. Secondly the patient had suffered from pain in swallowing, which had been greatly relieved by the use of orthoform. Dr. Tilley described the difficulties met with in the treatment of tubercle in the larynx and advised against operative measures in advanced cases except for palliative purposes. The terrible pain, sometimes amounting to agony, which is excited in some of these cases by every attempt to swallow, can often be successfully controlled by orthoform. This may be prescribed in the form of pastilles or may be insufflated over the ulcerated surface. Applied in this way a patient who previously had feared to swallow even his own saliva may be enabled to enjoy a good meal. Orthoform has little or no toxic properties and will relieve the pain of ulcerated surfaces in any part of the body.

*Asch's Operation for Deflected Nasal Septum.*

Dr. Herbert Tilley also showed a patient on whom he had successfully operated for extreme deflection of the nasal septum leading to complete occlusion of the right nasal fossa. He described the successive steps of the operation and spoke of the uselessness of nasal bougies, which only replace the septum temporarily, the vicious position returning upon their withdrawal.

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CASES WITH COMMENTS FROM THE SURGICAL CLINIC.

BY MR. HUTCHINSON.

(Continued from page 257)

*Ranula protruding in the Neck.*

The subject of this case was an old woman of 70, who had a tumour as large as a cricket ball projecting under the right side of her lower jaw. She said that it had been present for 10 years or more, but had latterly much increased. It was exceedingly soft when the jaw was at rest and freely fluctuated, but it became tense in the effort to swallow. The woman denied that she had anything

inside her mouth, but an examination immediately disclosed the ordinary conditions of a ranula under her tongue, and it was found that there was free communication between this and the tumour in the neck. The one could easily be made tense by pressure on the other. The diagnosis was thus quite clear.

I contented myself at the time with demonstrating the conditions, and with the remark that it was well-known that the salivary cystic tumours of the mouth, known as "Ranula," did occasionally make their way downwards into the neck. In doing this they probably pass backwards round the posterior edge of the mylo-hyoid in the reverse direction of Wharton's duct. Having once escaped from what is known as the "diaphragm of the mouth" made by the expansion of the mylo-hyoids, there is nothing to prevent free enlargement under the cover of the weak platysma. When once a cyst has made its escape from the mouth in this way all further enlargement takes place into the neck, and the patient ceases to be incommoded by bulging under the tongue. Hence the explanation of our patient's ignorance that she had anything in her mouth. Next came the question of treatment. As the patient was old and the swelling was of no inconvenience to her, except as a disfigurement, and as she had borne with it for ten years or more, it was doubtful whether from her point of view it was worth while to undergo any operative treatment. If such were undertaken the best plan would be to lay bare the tumour in the neck as freely as possible without puncturing it, and then to remove as much of it as could be taken away. By an incision through the mylo-hyoid it might, perhaps, be practicable to take the whole cyst, but it would be a tedious dissection, and very probably end in disappointment, since if once the cyst were pricked and collapsed it would become difficult to follow it. The result might very possibly be either a fistula in the neck or, if healing were complete, a reaccumulation in the mouth.

*The Potato-like Tumour of the Neck. Excision and Microscopic Examination. Carcinoma or Endothelioma?*

A very important case was sent to us for consultation by Mr. Hastings Gilford and Mr. Herbert Child from Reading. Its subject was a man of about 50 who had a lump almost of stony

hardness under the upper third of his sterno-mastoid muscle. It was a single mass, scarcely lobulated, and there was no evidence of enlargement of lymphatic glands near it. It was not adherent either to the skin or the muscle, but was more or less so over the course of the sheath of the vessels. It did not pass downwards in the neck, but slanted obliquely forwards from under the muscle. The question as to its being secondary to disease in the mouth had of course been entertained and investigated by the surgeons who



*The Potato-like Tumour of the Upper Neck. (From a photo in Mr. Hutchinson's Collection.)*

sent the patient, and after careful search nothing could be found. The tumour had been growing several months.

I remarked, respecting this case, that the tumour resembled those which many years ago I had described as "the potato-like tumour." They occurred in this position under the upper part of the muscle, and in their early stages exactly resembled a kidney potato placed obliquely across the neck. They grew very rapidly,

did not usually cause implication of the adjacent glands, but would ulcerate and fungate, and bring about death within a year.

Having regard to this very serious prognosis, and although undoubtedly the operation would be a somewhat formidable one, on account of the attachment of the tumour to the vessels, I would strongly recommend Mr. Gilford to remove it. If it were not removed there was nothing before the man but a very painful illness, and death within a short period. The patient returned to Reading, and Mr. Hastings Gilford excised the tumour. Its adhesions to



*The Potato-like Tumour of the Neck. (From a photo in Mr. Hutchinson's Collection.)*

the vein were so close that it was found necessary to remove an inch of the latter. The tumour was, however, got safely away, together with all the cellular tissue adherent to it. The patient made a good recovery.

In section it was solid, whitish, and cut much like a raw potato. It was made the subject of very careful microscopic examination by several skilled observers. Opinions differed somewhat as to details, but concurred in the view that it approached carcinoma much more closely than lympho-sarcoma. Captain Pinch considered it an endothelioma. The following is a report by Mr. J. Hutchinson, jun. :—

*Naked-eye examination.*—The tumour is firm and lobulated, is evidently an infiltrating one, its section is uneven and “granular” in appearance, there is a copious juice to be obtained on lightly scraping the section—and there is little doubt that the microscope will prove it to be a carcinoma.

*Microscopical examination.*—The section includes, besides the periphery of the tumour, a layer of infiltrated muscle, which is undergoing degeneration and becoming completely absorbed by the growth. There is no sort of capsule. The “granular” appearance of a section to the naked eye is seen to be due to large lobules of cells—closely packed together—of an epithelial type. These lobules are separated by very distinct strands of fibrous tissue and lymphatic spaces. There are also numerous blood-vessels with thin walls.

In some parts it might be difficult to distinguish the growth from a large round-celled or alveolar sarcoma, but there can be no doubt it is really a carcinoma—of what origin it is impossible to say.

We append two illustrations from photographs of the peculiar location of this form of tumour. It is almost always placed obliquely across the upper part of the neck.

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#### COMMITTEE OF INVESTIGATION ON YAWS.

(*Report of Meeting held November 14, 1901.*)

SIR WILLIAM KYNSEY read a detailed statement of the reasons which appeared to him to establish the specificity of Yaws and to distinguish it from syphilis. He held that, in regions where it prevailed, Yaws was a disease of country districts and syphilis of towns. He believed that the epidemics described in former times as “sibbens” and “button-scurvy” in Scotland and Ireland were “true Yaws,” but that the disease was now extinct in those countries. He thought that it was diminishing all over the world and that many other maladies—syphilis, lupus and tubercular affections—had often been confused with it. His own experience of Yaws had been obtained in Ceylon. Sydenham, he remarked, was the first authority who had regarded “Yaws” as identical with syphilis, and it was from following him that others “had fallen into error on this point.” He quoted Dr. Nicholls’ definition of “Yaws” with approval. He urged that “Yaws” was never preceded by any genital sore;

that its eruption was not polymorphous; did not leave scars; and usually terminated by resolution without constitutional disturbance.<sup>1</sup> He thought that the micrococci usually found in the tissues were the specific microbes of the disease. He held that the remedies for syphilis—mercury and iodides—were often injurious in Yaws. He quoted the experiments of Charlonis and the facts furnished by Dr. Powell and others in proof that Yaws does not protect from syphilis. He adduced also the opinions of Professor Koch and others, and made especial reference to the critical report recently published by Dr. Percy Boyden, R.N. (see "Statistical Reports of Health of Navy" for 1899).

In concluding his interesting and very able summary of facts in support of his views Sir William called upon Dr. MacLeod to state his conclusions as to the "Histology of Yaws."

Dr. MacLeod gave an account of his microscopic examination of portions of "Yaws" tissue which had been supplied to him from Ceylon, and exhibited a series of excellent drawings. As a full report of this investigation has already appeared in the *British Medical Journal* we need not repeat it here.

The most important point in his communication was the statement by Dr. MacLeod that he could not corroborate Dr. Nicholls' observations as to the presence of any specific microbe. He did not believe that there was one. His observations concerned minute features of peculiarity in the inflammatory process. These he believed implied that yaws and syphilis were different maladies.

It was suggested by a member of the Committee that the differences in the results of inflammation in yaws and in syphilis, which Dr. MacLeod believed that he had found, were simply differences between the framboesial lesions of syphilis and the papular and gummatous ones, and not those of two distinct diseases.

Dr. MacLeod admitted that this might to some extent be so. He had only had one opportunity of examining a framboesial eruption in connection with undoubted syphilis, and in this instance the histology did approach somewhat to that observed in "Yaws."

<sup>1</sup> Whilst Daniels and others support this statement by representing the disease as free from constitutional disorder, Nicholls, from statistics of the Yaws Hospitals, gives it a mortality of 2·5 per cent. Such a mortality is certainly far higher than that of syphilis.

## DR. GLANVILL CORNEY ON YAWS IN FIJI.

Mr. Hutchinson next read extracts from a letter which he had received from the Hon. Dr. Glanvill Corney, chief medical officer of Fiji, and Corresponding Associate of the Polyclinic.

Dr. Corney explained that the word for Yaws in general use in Fiji was "Tona," but that there was a native term "Coko," pronounced "Thoko." After stating that he had seen unmistakable yaws in Java, there called "Patek," and differentiated from syphilis



*The Primary Sore of Fijian Yaws with Satellite Growths. (From Dr. Corney's photo.)*

by both Dutch and native practitioners, Dr. Corney added, "if you could see cases of early secondary eruption or of the primary granuloma of Coko in Fijians, you would I feel sure remark striking differences from any syphilitic rash and from the Hunterian chancre. I enclose you a photograph which I took some years back of a case of primary Coko granuloma surrounded by smaller ones, like hen-and-chickens. It was in a Swede who had acquired it in Fiji."

Another photograph sent by Dr. Corney illustrated a Yaws granulomatous eruption in a native of the Solomon Islands, aged 24, the disease having been acquired in Fiji. We reproduce this

photograph, and for comparison place beside it that of an Englishman in whom a syphilitic eruption had taken a framboesial form.

A third photograph, sent by Dr. Corney, showed the granulomatous secondary eruption of so-called Yaws in a girl of German parentage, the disease having been contracted in Fiji (p. 319).

After stating that he did not wholly coincide with the views of



*The Secondary Eruption of Yaws (framboesial). (From Dr. Corney's photograph.)*

his friend Dr. Finucane (see POLYCLINIC, Vol. iv., pp. 172, 211), Dr. Corney added that, whilst quite admitting the parallelism in the course of the two diseases, he still believed that "the primary signs of Coko were essentially distinct from those of syphilis and that there were some other features of difference besides," adding: "We are somewhat struck by the refusal of many practitioners to believe

that there can be two distinct toxæmias productive of a train of symptoms which nearly approach one another in character."

In another paragraph of his letter it was stated, "Destructive ulceration of palate and pharynx, in the nature of lupus, is certainly a common sequela of Coko. It usually occurs after childhood and



*A Framboesial Eruption in Secondary Syphilis. (From a photograph taken for Mr. Hutchinson.)*

between the ages of 17 and 30, and sometimes involves also the larynx. I have also seen notched teeth. I will endeavour to get some bones saved of chronic tertiary framboesial cases, and if successful will send them to you for the Polyclinic Museum."

In commenting upon Dr. Corney's statements and the very interesting photographs which accompanied them, Mr. Hutchinson said that they were most valuable. It was, he believed, the first occasion on which the primary sore of Yaws had been depicted. It

was worthy of note that the fungating sore shewn was exactly like one which he had himself published as a chancre resulting from vaccination. Those who still contend that Yaws is not syphilis, and allege the difference in the primary sore, do not make sufficient



*The Framboesial Eruption of Secondary Yaws in a European infected in Fiji.  
(From Dr. Corney's photo.)*

allowance for the differences between chancres on the skin and those of the mucous membrane of the genitals. It is for the most part only on the latter that the characteristic Hunterian chancre is ever seen. As regards the secondary eruption no one he thought could look on Dr. Corney's illustration of Yaws on the face in a Fijian, and

his own of syphilis in an Englishman and say that they were not alike. Dr. Corney also told us that Yaws as seen in Fiji had tertiary symptoms just like those of syphilis. He had even seen notched teeth, a statement also made by Dr. Finucane. Thus it became clear that the Yaws indigenous to Fiji was a disease in all respects parallel with syphilis. Dr. Corney had correctly expressed the crux of the question in asking why there should be hesitation in admitting the possibility of the existence of two distinct poisons producing very similar effects. Well, in reply to that we might say that the hypothesis of two diseases is not required by the facts before us, and further that it is rendered highly improbable by the two important facts that tropical Yaws is always transformed into syphilis when its subject crosses the ocean, and that in European practice we every now and then encounter cases of unquestionable syphilis which assume the framboesial type supposed to be peculiar to Yaws. He therefore believed firmly that there is but one specific poison, and that Yaws is only a variant of syphilis.

#### DR. COLLINGWOOD ON YAWS.

Dr. Collingwood next stated his experience of Yaws as observed by himself in Fiji, Samoa and Ceylon. He said that unquestionably most of the phenomena were not to be distinguished from those of syphilis. Tertiary symptoms, lupoid ulcerations, gummatæ, destructive ulceration of the nose and throat were common. In Fiji the natives imported very large quantities of iodide of potassium to relieve them of the periosteal nodes from which so many of them suffered. He had seen syphilitic teeth. It was true that the primary sore was but rarely recognised, and that the disease was usually contracted in youth. He agreed, however, with what Mr. Hutchinson had just said as to the difficulty of diagnosing primary sores on other parts than the genitals, and this, he felt sure, was the explanation of the circumstance that the first stage of "Yaws" was so often overlooked.

Sir William Kynsey said that after the evidence which had been adduced he thought there could be no doubt that the Fijian disease called Thoko and hitherto confounded with "Yaws" was really syphilis. He held, however, that the Ceylon malady was different.

Dr. Collingwood replied that he had seen the disease in both countries, and could assure Sir William that it was the same.

Thus it will be seen that at this Committee several important items of advance were established :—

- (1) The absence of any specific microbe (Dr. MacLeod).
  - (2) The identity of Fijian Thoko with syphilis (asserted by Finucane and Collingwood and fully admitted by Kynsey).
  - (3) The identity of Fijian Thoko with the Parangi or True Yaws of Ceylon (asserted by Dr. Collingwood).
  - (4) The existence and character of the primary sore (demonstrated by Dr. Corney).
  - (5) The occurrence of tertiary symptoms (Collingwood, Corney and others).
- 

#### COLLEGE NOTES.

If it be true that the "nation may be called happy which has no history," our College may be congratulated at the present time. The past month has been uneventful, but the attendance in our classes and consultation theatres has been larger than ever before.

\*       \*       \*

THE proposed visit to the Margate Infirmary has been deferred to the spring months.

\*       \*       \*

As Mr. Hutchinson will probably be out of England (at the Cape) from the present date until the middle of March, other arrangements have become necessary for the Thursday consultations. His place will be efficiently filled by other surgeons.

\*       \*       \*

The Council has appointed Standing Committees of Investigation on the subjects of Vaccination and of Cancer. It is proposed at an early opportunity to have a discussion on the present position of Vaccination in England.

## CORRESPONDENCE AND ANSWERS.

LOCAL DISTRIBUTION OF CANCER IN ENGLAND.—One of the most important results of Dr. Haviland's laborious researches was the demonstration of excessive mortality from cancer in the neighbourhood of rivers and on a clay-soil. His data were the annual death rates from cancer amongst women upwards of 35 years of age. This method of estimate seems to be free from the obvious fallacies which attend calculations based upon the gross mortality of all ages. He found that the average cancer mortality per 10,000 of women who had reached this age was 14, that on clay soils it reached 19, whilst on limestone it was only 9—we omit decimals. Perhaps his most plausible explanation of this difference is that want of tone in damp districts renders the tissues prone to malignant growths.

\* \* \*

THE FALKLAND ISLANDS.—These islands, according to the latest report, are prosperous. They support nearly 800,000 sheep and a human population of 2,000. Stanley, the chief town, is reported to be crowded and "there is no house available for love or money."

\* \* \*

THE CERVICAL VERTEBRAE.—Faith in the permanency of type forms would appear to have been a little vague in Arbuthnot's days (1735). Writing of apoplexy, he says: "The causes of this disease are a particular conformation of the body, as a short neck; for there be some *who have fewer vertebrae in their necks than others*; long-necked people are subject to consumptions and short-necked to apoplexies, though this rule is not generally (*i.e.*, universally) true."

\* \* \*

THE ROYAL SOCIETY AND MALARIA.—The following is an extract from the Report of the Royal Society just issued:—*Malaria*.—Reports from Dr. Daniels upon the distribution of Anopheles in East Africa, and from Drs. Christophers and Stevens upon malarial infection on the West Coast, have, since the last Report of the Council, been published in the form of Reports to the Malaria Committee. The two last-named observers are now carrying out researches in India, the scheme including the determination of the exact conditions by which malarial infection is brought about under a fresh set of conditions as in Indian cantonments, the conditions of infection in which relapses are possible, the exact influence of surrounding temperature on the development of the parasites in Anopheles, the possibility of infected Anopheles while hibernating carrying a parasite from season to season, and the nature of Blackwater fever, including the historical investigation on the spot as to its advent and spread in India.

\* \* \*

IN a footnote on p. 227 of Mr. Berry's "Diseases of the Thyroid Gland," we find, "I have known several instances in which young girls have been sent to school in a goitrous district and have there developed the disease. Upon leaving the district the goitre disappeared spontaneously."

\* \* \*

WE owe to Dr. Alfred Gubb (*v. Times*, November 5) the practical suggestion that in all cases in which non-vaccinated persons are treated in small-pox hospitals their relatives should be compelled to pay for their support. The Asylums Board already possesses the power.

\* \* \*

MR. S. GARRETT ANDERSON (*v. Times*, November 5) draws attention to the fact that in badly vaccinated France the mortality from small-pox per 100,000 population is 6·92, whilst in Germany (well protected) it is only 0·03.

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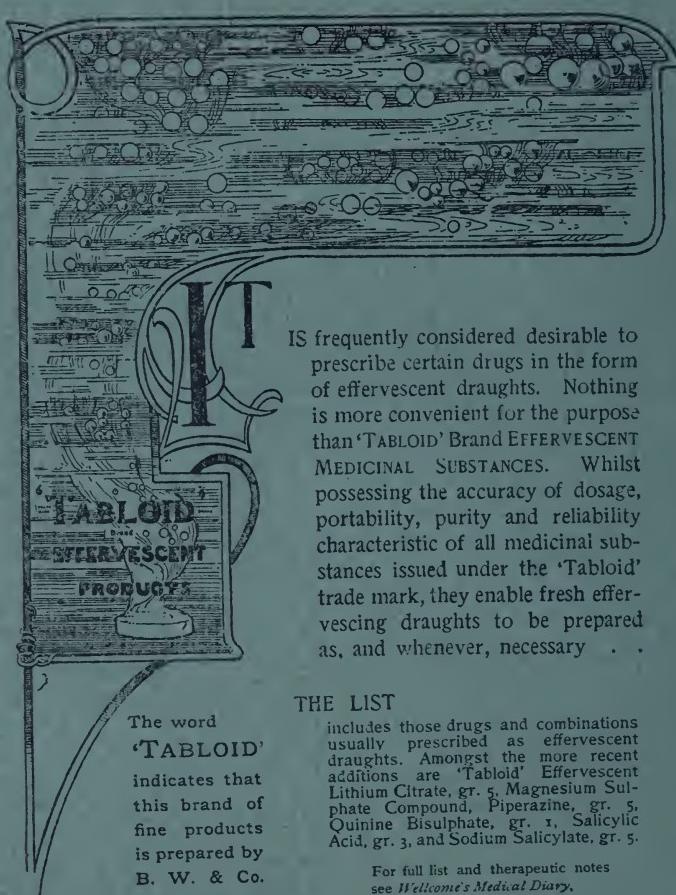
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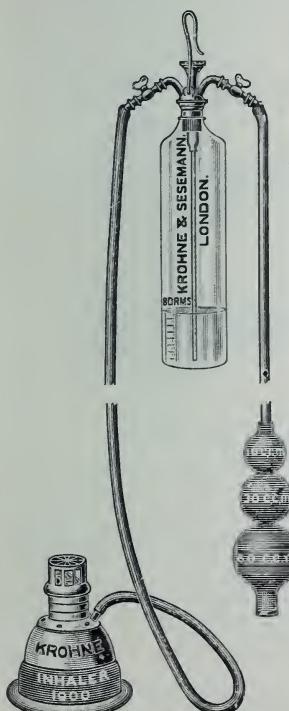
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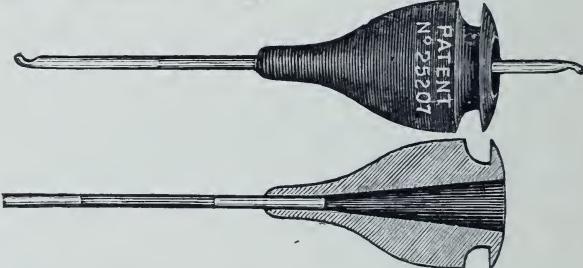
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THIRD DAY.—*Resections, &c.*

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FOURTH DAY.—*Amputations.*

*Foot.*—Great Toe, Syme, Subastragaloid.

*Leg.*

*Knee.*—Stephen Smith or Stokes-Gritti.

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*Hand.*—Thumb, Wrist.

*Fore-arm.*

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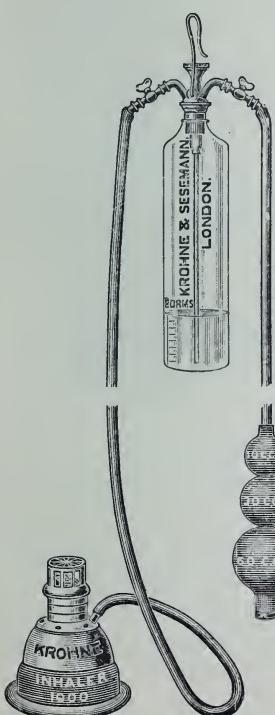
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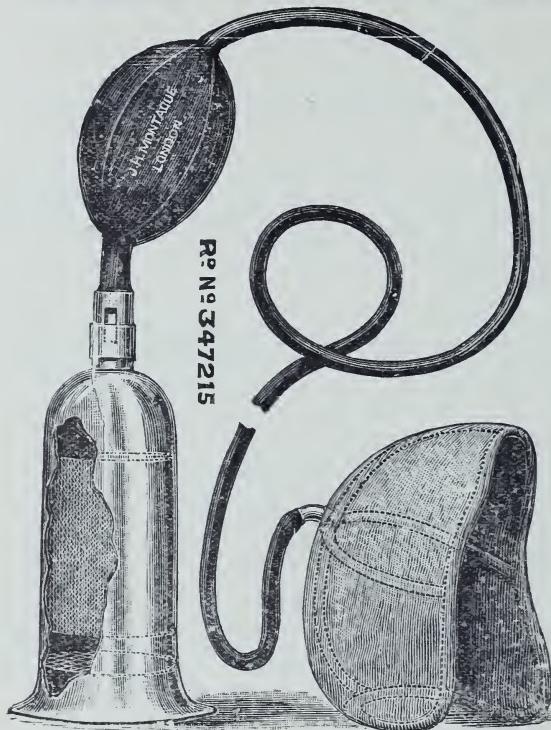
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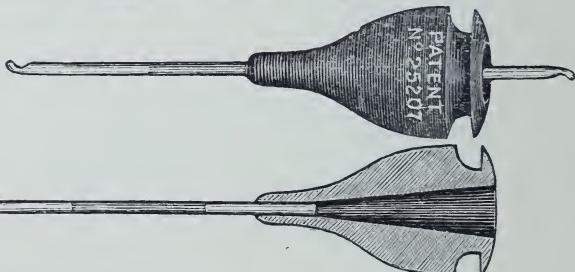
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Cliniques at 4 p.m.

MONDAYS. (Skin)	TUESDAYS. (Medical)	WEDNESDAYS. (Surgical)	THURSDAYS. (Surgical)	FRIDAYS. (Eye, Ear, Nose, and Throat)
September 9 COLLEGE OPENS	September 10 Dr. W. Ewart	September 11 Mr. J. Cantlie	September 12 Mr. Hutchinson	September 13 Dr. Jobson Horne
September 16 Dr. J. Galloway	September 17 Dr. J. E. Squire	September 18 Mr. Johnson Smith	September 19 Mr. Hutchinson	September 20 Mr. R. Lake
September 23 Dr. A. Whitfield	September 24 Dr. Harry Campbell	September 25 Mr. P. W. De Santis	September 26 Mr. Hutchinson	September 27 Mr. Work Dodd
September 30 Dr. A. Whitfield	October 1 Dr. Seymour Taylor	October 2 Mr. R. Harrison	October 3 Mr. Hutchinson	October 4 Dr. H. Tilley
October 7 Dr. J. F. Payne	October 8 Dr. C. Theo. Williams	October 9 Mr. P. J. Freyer	October 10 Mr. Hutchinson	October 11 Dr. Dundas Grant
October 14 Dr. J. Galloway.	October 15 Sir W. H. Broadbent	October 16 Mr. A. H. Tubby	October 17 Mr. Hutchinson	October 18 Mr. Marcus Gunn
October 21 Dr. J. J. Pringle	October 22 Dr. James Taylor	October 23 Mr. J. Berry	October 24 Mr. Hutchinson	October 25 Dr. St. Clair Thomson
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### Special Courses of Lectures at 5.15 p.m.

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October 2nd and 9th—Sir FELIX SEMON, M.D., F.R.C.P.  
October 16th—R. BRUDENELL CARTER, Esq., F.R.C.S.  
October 30th—Sir WM. H. BROADBENT, Bart., LL.D., F.R.S.  
November 13th—Prof. G. SIMS WOODHEAD, M.A., M.D., of Cambridge.  
November 27th—Prof. G. MARKHAM SKERRITT, M.D., F.R.C.P., of Bristol.  
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Clinical Examination of the Nervous System ... ...	(James Taylor, M.D., F.R.C.P. Harry Campbell, M.D., F.R.C.P.)
Practical Ophthalmology : the use of the Ophthalmoscope	(L. V. Cargill, F.R.C.S. John Griffith, F.R.C.S.)
and Refraction ... ...	(Norman MacLehose, M.B., C.M.)
Practical Otology ... ...	(J. Dundas Grant, M.D., F.R.C.S. Richd. Lake, F.R.C.S.)
Practical Rhinology and Laryn- gology ... ...	(St.Clair Thomson, M.D., F.R.C.S. Herbert Tilley, M.D., F.R.C.S. W. Jobson Horne, M.B., M.R.C.P.)
The Application of the Röntgen Rays ... ...	F. Harrison Low, M.B.
Clinical Microscopy ... ...	A. E. Hayward Pinch, F.R.C.S.

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Practical Bacteriology ...	...	
Mental Diseases ...	...	Maurice Craig, M.D., M.R.C.P.
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Short courses of didactic lectures on special subjects are delivered every month.

The Laboratory is open for private research to Members upon terms which can be ascertained on inquiry.

Analyses are undertaken and reports furnished upon pathological specimens submitted for examination.

The Vacation Term of practical classes commences on Monday, Sept. 9.

TIME TABLE OF CLASSES OF VACATION SESSION, SEPT. 9 TO 27.

CLASS.	LECTURERS.	MON.	TUES.	WED.	THURS.	FRI.	SAT.	1ST LECT.
Clinical Microscopy	Mr. H. Pinch	2 p.m.	11 a.m.	2 p.m.	11 a.m.	—	—	Mon., Sept. 9
Examination of Nervous System	Dr. H. Campbell	—	2.30 p.m.	—	--	2.30 p.m.	—	Tues., Sept. 10
Röntgen Rays	Dr. H. Low	—	—	—	3 p.m.	—	—	Thurs., Sept. 12
Applied Anatomy	Dr. S. Taylor Mr. J. Cantlie	—	5 p.m..	—	—	9 a.m.	—	Tues., Sept. 10
Practical Otology	Dr. D. Grant Mr. R. Lake	5 p.m.	9 a.m.	—	—	—	—	Mon., Sept. 9
Practical Laryngology	Dr. W. J. Horne	—	—	5 p.m.	—	—	2.30 p.m.	Wed., Sept. 11
Practical Ophthalmology	Mr. V. Cargill	—	—	—	5 p.m.	5 p.m.	—	Thurs., Sept. 12

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*Nerves.*—Spinal Accessory, Musculo-spiral, Sciatic.

SECOND DAY.—*Head and Neck.*

*Trephining Operations.*—Middle Meningeal Artery, Lateral Sinus, Mastoid Antrum, Frontal Sinus.

Removal of Eyeball, Oesophagotomy, Laryngectomy, Removal of Tongue, Avulsion of Gasserian Ganglion (Hartley-Krause).

THIRD DAY.—*Resections, &c.*

Upper Jaw, Lower Jaw, Elbow, Wrist, Hip, Knee, Osteotomy of Femur (Macewen), Exarticulation at Hip.

FOURTH DAY.—*Amputations.*

*Foot.*—Great Toe, Syme, Subastragaloid.

*Leg.*

*Knee.*—Stephen Smith or Stokes-Gritti.

*Thigh.*

*Hand.*—Thumb, Wrist.

*Fore-arm.*

*Arm.*—Exarticulation at Shoulder.

FIFTH DAY.—*Abdominal Operations, &c.*

Lithotomy, Suprapubic Cystotomy, Removal of Appendix, Inguinal Colotomy, Gastrostomy, Cholecystostomy, Interscapulo-Thoracic Amputation (Berger).

SIXTH DAY.—*Abdominal Operations, &c.*

Enterostomy, Enterectomy and Intestinal Suturing, Gastro-Enterostomy, Application of Murphy's Button, Application of Mayo Robson's or some other form of Bobbin, Lumbar Colotomy, Nephrectomy, Varicocele, Removal of Testicle.

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## SCHEDULE OF CLINIQUES AND LECTURES

From SEPTEMBER to DECEMBER 1901.

Cliniques at 4 p.m.

MONDAYS. (Skin)	TUESDAYS. (Medical)	WEDNESDAYS. (Surgical)	THURSDAYS. (Surgical)	FRIDAYS. (Eye, Ear, Nose, and Throat)
September 9 COLLEGE OPENS	September 10 Dr. W. Ewart	September 11 Mr. J. Cantlie	September 12 Mr. Hutchinson	September 13 Dr. Jobson Horne
September 16 Dr. J. Galloway	September 17 Dr. J. E. Squire	September 18 Mr. Johnson Smith	September 19 Mr. Hutchinson	September 20 Mr. R. Lake
September 23 Dr. A. Whitfield	September 24 Dr. Harry Campbell	September 25 Mr. P. W. De Santi	September 26 Mr. Hutchinson	September 27 Mr. Work Dodd
September 30 Dr. A. Whitfield	October 1 Dr. Seymour Taylor	October 2 Mr. R. Harrison	October 3 Mr. Hutchinson	October 4 Dr. H. Tilley
October 7 Dr. J. F. Payne	October 8 Dr. C. Theo. Williams	October 9 Mr. P. J. Freyer	October 10 Mr. Hutchinson	October 11 Dr. Dundas Grant
October 14 Dr. J. Galloway.	October 15 Sir W. H. Broadbent	October 16 Mr. A. H. Tubby	October 17 Mr. Hutchinson	October 18 Mr. Marcus Gunn
October 21 Dr. J. J. Pringle	October 22 Dr. James Taylor	October 23 Mr. J. Berry	October 24 Mr. Hutchinson	October 25 Dr. St. Clair Thomson
October 28 Mr. Malcolm Morris	October 29 Dr. Harry Campbell	October 30 Mr. A. H. Tubby	October 31 Mr. Hutchinson	November 1 Mr. R. Lake
November 4 Dr. Radcliffe Crocker	November 5 Dr. R. L. Bowles	November 6 Mr. J. Cantlie	November 7 Mr. Hutchinson	November 8 Mr. Treacher Collins
November 11 Dr. J. F. Payne	November 12 Sir W. H. Broadbent	November 13 Mr. E. W. Roughton	November 14 Mr. Hutchinson	November 15 Dr. H. Tilley
November 18 Dr. T. Colecott Fox	November 19 Dr. Seymour Taylor	November 20 Mr. Howard Marsh	November 21 Mr. Hutchinson	November 22 Dr. Dundas Grant
November 25 Mr. Malcolm Morris	November 26 Dr. W. Ewart	November 27 Mr. P. W. De Santi	November 28 Mr. Hutchinson	November 29 Mr. Ernest Clarke
December 2 Dr. J. Galloway	December 3 Dr. James Taylor	December 4 Mr. Reg. Harrison	December 5 Mr. Hutchinson	December 6 Dr. St. Clair Thomson
December 9 Dr. J. J. Pringle	December 10 Dr. Guthrie Rankin	December 11 Mr. Johnson Smith	December 12 Mr. Hutchinson	December 13 Dr. Dundas Grant
December 16 Mr. Malcolm Morris	December 17 Dr. C. Theo. Williams	December 18 Mr. J. Berry	December 19 Mr. Hutchinson	December 20 Mr. N. MacLehose

### Clinical Lectures at 5.15 p.m.

### Special Courses of Lectures at 5.15 p.m.

1901.

- October 2nd and 9th—Sir FELIX SEMON, M.D., F.R.C.P.  
October 16th—R. BRUDENELL CARTER, Esq., F.R.C.S.  
October 30th—Sir WM. H. BROADBENT, Bart., LL.D., F.R.S.  
November 13th—Prof. G. SIMS WOODHEAD, M.A., M.D., of Cambridge.  
November 27th—Prof. G. MARKHAM SKERRITT, M.D., F.R.C.P., of Bristol.  
December 4th—Sir W. MITCHELL BANKS, LL.D., F.R.C.S., of Liverpool.  
December 18th—J. F. PAYNE, Esq., M.D., F.R.C.P.
- October 11th, 18th, and 25th—Dr. J. M. H. MACLEOD, "Some observations on the Histo-Pathology of Skin Disease."  
October 14th, 21st, and 28th—Mr. H. WORK DODD, "Some practical points in the examination of the Eye, not including Refraction."  
November 8th, 15th, and 22nd—Dr. J. DUNDAS GRANT, "Nerve Deafness: its varieties, diagnosis, and treatment."  
November 11th, 18th, and 25th—Mr. J. JACKSON CLARKE, "The Protozoa in Pathology."  
December 2nd, 9th, and 16th—Mr. A. CARLESS, "The Surgery of the Stomach."  
December 6th, 13th, and 20th—Dr. C. O. HAWTHORNE, "Medical Ophthalmology."

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1901.

## PRACTICAL CLASSES.

Applied Anatomy (Medical and Surgical), Physical Diagnosis	(	Seymour Taylor, M.D., F.R.C.P. J. Edward Squire, M.D., M.R.C.P. James Cantlie, M.B., F.R.C.S. Albert Carless, M.S., F.R.C.S.
Clinical Examination of the Nervous System ...	...	James Taylor, M.D., F.R.C.P. Harry Campbell, M.D., F.R.C.P.
Practical Ophthalmology: the use of the Ophthalmoscope and Refraction ...	...	L. V. Cargill, F.R.C.S. Norman MacLehose, M.B., C.M.
Practical Otology ...	...	J. Dundas Grant, M.D., F.R.C.S. Richd. Lake, F.R.C.S.
Practical Rhinology and Laryn- gology ...	...	St.Clair Thomson, M.D., F.R.C.S. Herbert Tilley, M.D., F.R.C.S. W. Jobson Horne, M.D., M.R.C.P.
The Application of the Röntgen Rays ...	...	F. Harrison Low, M.B.
Clinical Microscopy ...	...	A. E. Hayward Pinch, F.R.C.S.

## CLASSES IN ASSOCIATION WITH THE COLLEGE.

Practical Bacteriology ...	...	R. Tanner Hewlett, M.D., M.R.C.P.
Mental Diseases ...	...	Maurice Craig, M.D., M.R.C.P.
Hygiene and Public Health	...	A. Wynter Blyth, M.R.C.S., F.C.S.
Operative Surgery ...	...	W. Johnson Smith, F.R.C.S.

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Practical Application of Röntgen Rays. Thursdays, 3 P.M., commences November 7. Dr. Harrison Low.

Practical Ophthalmology: the Use of the Ophthalmoscope and Refraction. Fridays, 5 to 7 P.M., commences November 8.  
Mr. L. Vernon Cargill.

Practical Rhinology and Laryngology. Wednesdays, 5 to 7 P.M., commences November 5. Dr. H. Tilley.

Practical Otology. Mondays, 5 to 7 P.M., commences November 4.  
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*Nerves.*—Spinal Accessory, Musculo-spiral, Sciatic.

SECOND DAY.—*Head and Neck.*

*Trephining Operations.*—Middle Meningeal Artery, Lateral Sinus, Mastoid Antrum, Frontal Sinus.

Removal of Eyeball, (Esophagotomy, Laryngectomy, Removal of Tongue, Avulsion of Gasserian Ganglion (Hartley-Krause).

THIRD DAY.—*Resections, &c.*

Upper Jaw, Lower Jaw, Elbow, Wrist, Hip, Knee, Osteotomy of Femur (Macewen), Exarticulation at Hip.

FOURTH DAY.—*Amputations.*

*Foot.*—Great Toe, Syme, Subastragaloid.

*Leg.*

*Knee.*—Stephen Smith or Stokes-Gritti.

*Thigh.*

*Hand.*—Thumb, Wrist.

*Fore-arm.*

*Arm.*—Exarticulation at Shoulder.

FIFTH DAY.—*Abdominal Operations, &c.*

Lithotomy, Suprapubic Cystotomy, Removal of Appendix, Inguinal Colotomy, Gastrostomy, Cholecystostomy, Intercapulo-Thoracic Amputation (Berger).

SIXTH DAY.—*Abdominal Operations, &c.*

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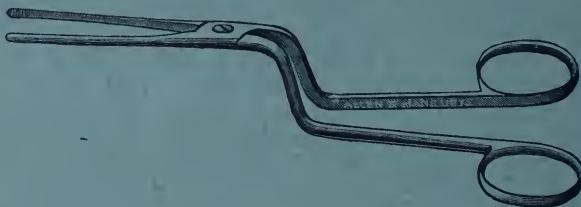
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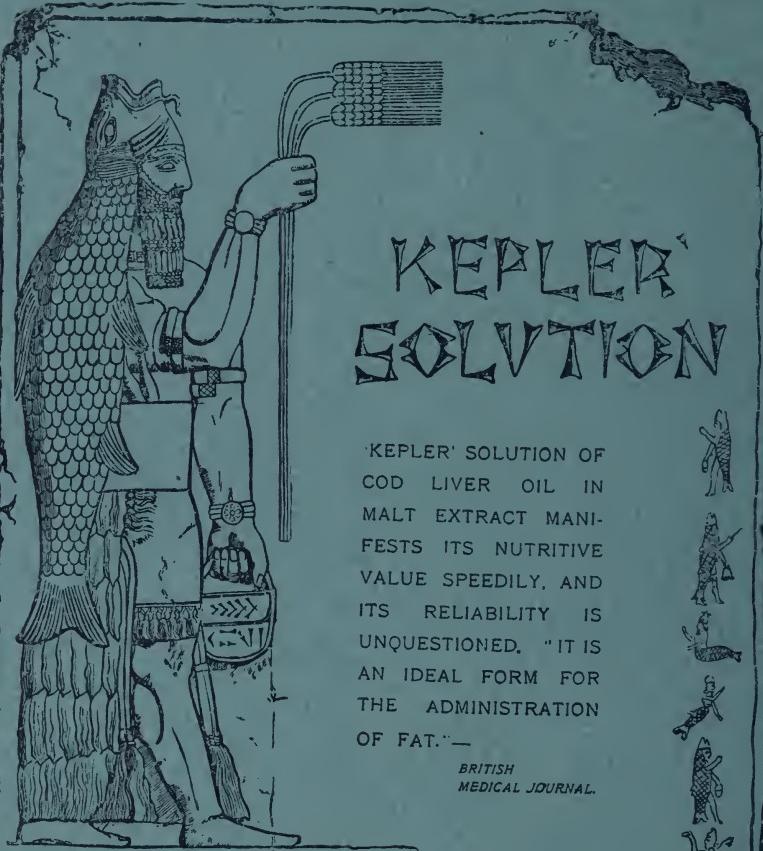
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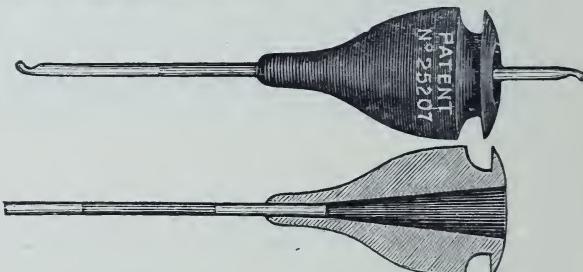
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September 9 COLLEGE OPENS	September 10 Dr. W. Ewart	September 11 Mr. J. Cantlie	September 12 Mr. Hutchinson	September 13 Dr. Jobson Horne
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September 23 Dr. A. Whitfield	September 24 Dr. Harry Campbell	September 25 Mr. P. W. De Santi	September 26 Mr. Hutchinson	September 27 Mr. Work Dodd
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SECOND DAY.—*Head and Neck.*

*Trephining Operations.*—Middle Meningeal Artery, Lateral Sinus, Mastoid Antrum, Frontal Sinus.

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THIRD DAY.—*Resections, &c.*

Upper Jaw, Lower Jaw, Elbow, Wrist, Hip, Knee, Osteotomy of Femur (Macewen), Exarticulation at Hip.

FOURTH DAY.—*Amputations.*

*Foot.*—Great Toe, Syme, Subastragaloid.

*Leg.*

*Knee.*—Stephen Smith or Stokes-Gritti.

*Thigh.*

*Hand.*—Thumb, Wrist.

*Fore-arm.*

*Arm.*—Exarticulation at Shoulder.

FIFTH DAY.—*Abdominal Operations, &c.*

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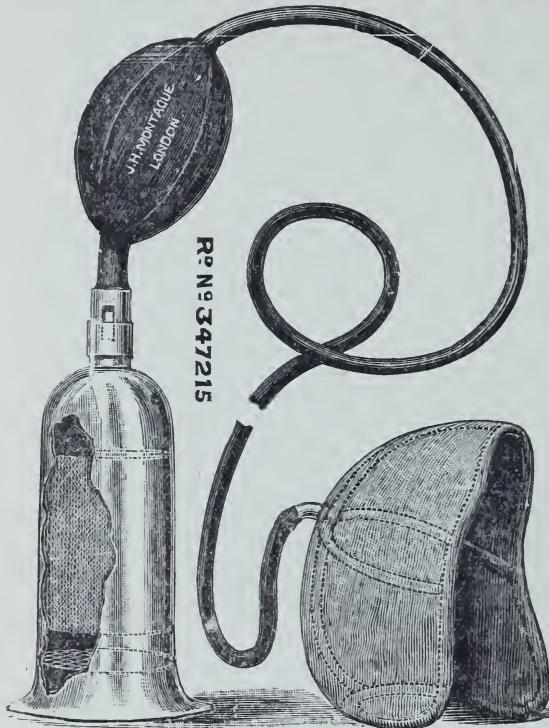
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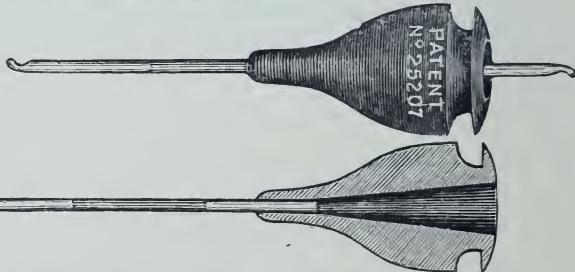
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